Name:

Date:

DOB:

What is the purpose of your visit?

Describe your problem

* Signs and symptoms:
* How long have these symptoms been occuring?
* What activities/interventions make you feel better?
* What activities/interventions make you feel worse?
* Are there different times of day where you feel better or worse?

*If you are experiencing pain*

* On a scale of 1-10, how bad is your discomfort?
* What words would you use to describe your discomfort (sharp, aching, throbbing, etc)?
* What specific areas of your body are hurting?
* What activities/interventions make you feel better?
* What activities/interventions make you feel worse?
* Are there different times of day where you feel better or worse?
* Any swelling, redness, warmth, or decreased range of motion in the affected area?

How have your symptoms affected your activities of daily living (dressing yourself, cooking, cleaning, etc.) and your hobbies?

Does anyone else in your family have/has had symptoms that match these?

What possible causes for your symptoms are you concerned about?

What health markers have you been tracking (blood glucose, blood pressure, temperature, number of episodes of symptoms, etc)?

What interventions have you already tried?

Additional Questions: