

Potrero Chiropractors  A Wellness Center
SYMPTOM SURVEY

| | |
|---------------------|--------------------|
| Patients Name _____ | Today's Date _____ |
|---------------------|--------------------|

TELL US WHERE YOU HURT
Shade the Area of Pain. Label with Appropriate Symbol

- P** = Pain (Dolor)
- W** = Weakness (Debilidad)
- N** = Numbness (Entumecimiento)
- B** = Burning (Ardor/Caliente)
- S** = Spasm (Espasmo de Musculo)
- ST** = Stiffness (Tiesura)
- T** = Tingling (Estremecimiento)



| Area of Pain (check mark each area of pain) | Pain Scale (circle numbers) | | | Amount of Time You Are in Pain (circle one for each body part) | | | | | | | | | | | |
|--|--------------------------------|----------|--------|---|---------------------------|-----------------------|------------------------|---|---|---|----|---|---|---|---|
| | Mild | Moderate | Severe | Occasional 0 to 25% | Intermittent 25 to 50% | Frequent 50 to 75% | Constant 75 to 100% | | | | | | | | |
| <input type="checkbox"/> Head | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0 | I | F | C |
| <input type="checkbox"/> Neck | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0 | I | F | C |
| <input type="checkbox"/> Shoulder(s) <input type="checkbox"/> Lt. <input type="checkbox"/> Rt. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0 | I | F | C |
| <input type="checkbox"/> Arm(s) <input type="checkbox"/> Lt. <input type="checkbox"/> Rt. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0 | I | F | C |
| <input type="checkbox"/> Upper Back | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0 | I | F | C |
| <input type="checkbox"/> Middle Back | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0 | I | F | C |
| <input type="checkbox"/> Lower Back | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0 | I | F | C |
| <input type="checkbox"/> Hip(s) <input type="checkbox"/> Lt. <input type="checkbox"/> Rt. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0 | I | F | C |
| <input type="checkbox"/> Leg(s) <input type="checkbox"/> Lt. <input type="checkbox"/> Rt. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0 | I | F | C |
| <input type="checkbox"/> Other _____ | | | | | | | | | | | | | | | |

List Any Other Current Symptoms: _____

Signature of Patient or Guardian _____