Great Health Chiropractic
The Journey To Great Health Starts with Us

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SYMPTOM SURVEY

Name:______________________________ Date:______________________

1. My painful or problem area(s) which originally brought me here were:
   a) d)
   b) e)
   c) f)

2. Overall, the condition(s) above my chiropractor is treating has:
   ( ) Improved ( ) Not Improved

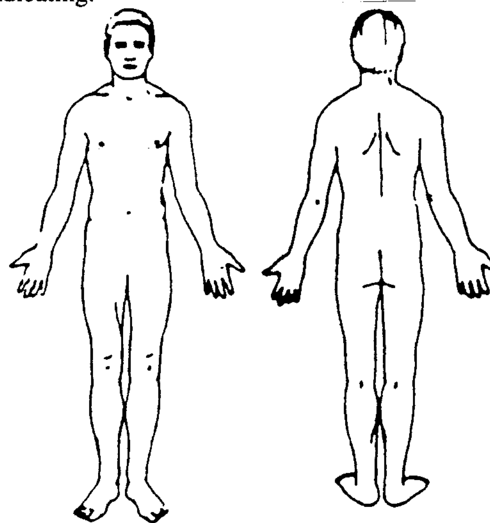
   a) If any have not improved, please explain:

3. Overall, how much has your pain/discomfort improved since your first day here:

   (Circle One) 0 10 20 30 40 50 60 70 80 90 100 %

4. Describe your present symptom(s) on the following diagram by indicating:

Dull ache........................xxx
Pins and Needles............000
Numbness......................- - -
Burning...........................+ + +
Stabbing..........................s s s
Other...............................///



5. Place a mark on this scale indicating your pain level today:

6. Have you had a recent flair-up of your pain/discomfort:
   ( ) Yes ( ) No

7. Overall, are you satisfied with the treatments you have received up until now:
   ( ) Yes ( ) No

8. Do you feel that the treatments are addressing your overall problem(s):
   ( ) Yes ( ) No

9. Do you feel the treatments in this office have been <u>reasonable and necessary</u> to help correct your problem:
   ( ) Yes ( ) No

10. Is there any part of the treatment program you are unhappy with:
    ( ) Yes ( ) No

11. Other complaints or problems I would like the doctor to look at today:

Please sign below:

____

Patients Signature

By my signature above, I certify that the above information is accurate and true

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