Symptom Diagram

Patient Name: ____ Chosen Name: ______________________

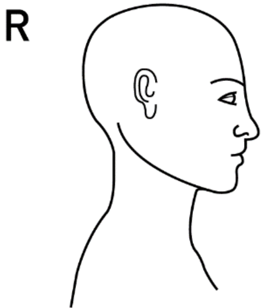
Preferred Salutation/Pronoun (optional)_____________ File #:__________________ Date: ___________________

In the diagrams provided below, please mark the areas on your body, which you feel best represent the pain(s) or sensation(s) you are experiencing. Please include *all* areas. Use the symbols provided below. Please draw in the face on the diagram.

SYMBOLS:

Numbness	=======	Pins and Needles	**ooooo**
Burning	**x x x x x x**	Stabbing & Sharp	**~~~~~**
Dull & aching	**? ? ? ? ? ?**	Stiff & Tight	**2 2 2 2 2**

R



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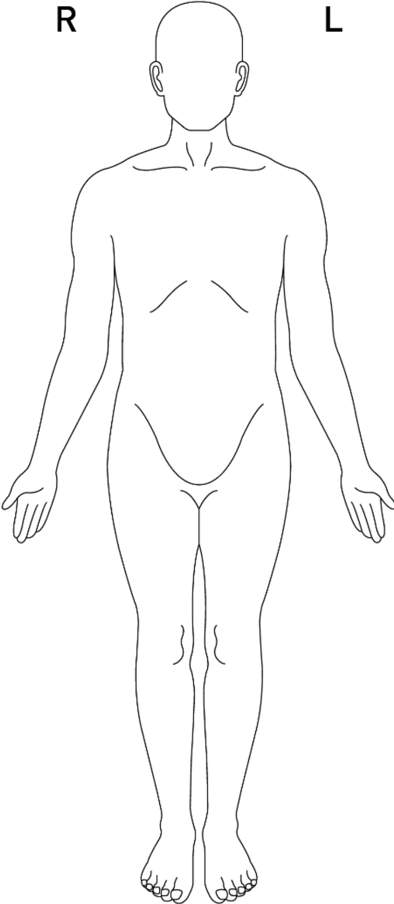

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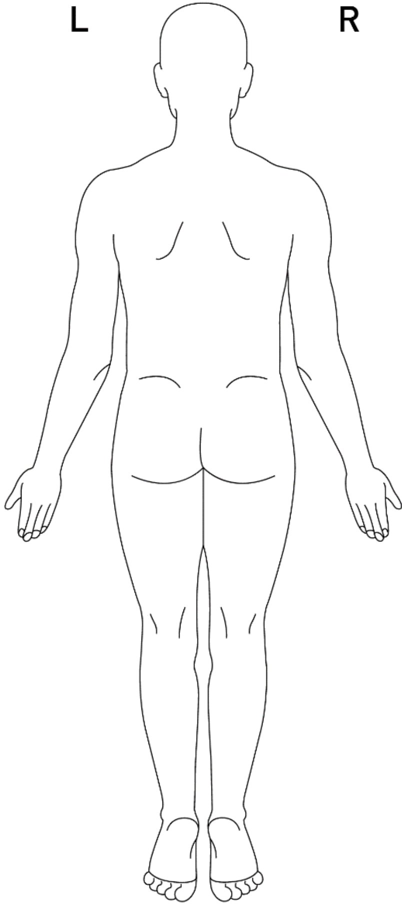

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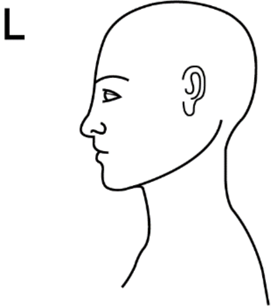

Health Status Survey

Patient Name: ____ Chosen Name: ____________________

Preferred Salutation/Pronoun (optional)____________ File #:________________ Date: _________________

Present Symptoms: Please ✓the box for any conditions or symptoms currently causing you problems.
Past Symptoms: Please X the box for any conditions or symptoms that you have had in the past.

Gastrointestinal

- ☐ Poor appetite
- ☐ Indigestion
- ☐ Excess hunger
- ☐ Belching or gas
- ☐ Vomiting
- ☐ Pain over stomach
- ☐ Constipation
- ☐ Hemorrhoids (piles)
- ☐ Jaundice
- ☐ Gall bladder trouble
- ☐ Intestinal worms
- ☐ Ulcer
- ☐ Diabetes
- ☐ Diarrhea

Neurologic

- ☐ Dizziness
- ☐ Fainting
- ☐ Problem speaking
- ☐ Problem swallowing
- ☐ Blurred vision
- ☐ Double vision
- ☐ Clumsiness
- ☐ Numbness or tingling

Cardiovascular

- ☐ Bleeding disorder
- ☐ High blood pressure
- ☐ Chest pain
- ☐ Stroke
- ☐ Hardening of arteries
- ☐ Varicose veins
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Heart/blood disease
- ☐ Angina

General Symptoms

- ☐ Loss of Consciousness
- ☐ Blackouts
- ☐ Headache
- ☐ Fever
- ☐ Excess Sweating
- ☐ Night sweats
- ☐ Loss of Weight
- ☐ Night pain
- ☐ Generalized pain
- ☐ Convulsions

Genitourinary

- ☐ Trouble urinating
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Bedwetting
- ☐ Prostate trouble

Menstrual related

- ☐ Painful menstruation
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular/absent cycle
- ☐ Cramping/backache
- ☐ Abnormal vaginal discharge
- ☐ Swollen breasts
- ☐ Lump in breasts

Have you had a bone density scan?
☐ Yes ☐ No

Currently on birth control?
☐ Yes ☐ No

Previously on birth control?
☐ Yes ☐ No

Number of pregnancies: _____

Number of children: _______________

Muscles & Joints

- ☐ Sore/stiff neck
- ☐ Low back pain
- ☐ Mid back ache
- ☐ Painful tailbone
- ☐ Shoulder pain
- ☐ Arm/forearm pain
- ☐ Elbow pain
- ☐ Wrists/hand pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Ankle/foot trouble
- ☐ Arthritis
- ☐ Loss of strength

Have you ever had any fractures?
☐ Yes ☐ No
If yes - where?
____

Have you ever been in a car accident?
☐ Yes ☐ No
If yes - when?
____

Have you ever been hospitalized?
☐ Yes ☐ No
If yes – why/ when?
____

Are you currently a smoker?
☐ Yes ☐ No
If yes – how much? _________

Did you previously smoke?
☐ Yes ☐ No
If yes – how much? ________

Eyes/Ears/Nose/Throat

- ☐ Failing vision
- ☐ Eye pain
- ☐ Failing hearing
- ☐ Earache
- ☐ Ring/buzz in ears
- ☐ Frequent colds
- ☐ Sinus infection
- ☐ Enlarged thyroid
- ☐ Enlarged glands
- ☐ Nervousness
- ☐ Convulsions

Respiratory

- ☐ Asthma
- ☐ Chronic cough
- ☐ Spitting up phlegm
- ☐ Spitting up blood
- ☐ Difficulty breathing

Skin

- ☐ Rashes/itching
- ☐ Bruise easy
- ☐ Dryness
- ☐ Boils
- ☐ Hives (allergies)

Have you ever been diagnosed with:

Cancer	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Hep A/B/C	☐ Yes	☐ No

Have you ever had any mental health issues?

- ☐ Depression
- ☐ Anxiety
- ☐ Nervousness
- ☐ Trauma related condition
- ☐ Substance related condition
- ☐ Personality disorder
- ☐ Bipolar disorder

Other (please list):
____
____
____

Medications (please list):
____
____
____

Clinician comments and signature:
____
____