TRUE HEALTH CENTER
SYMPTOM QUESTIONAIRE

Name: _____ Date: _____

What brings you in today: _____

1. Pain type: Achy ____ Dull ____ Sharp ___ Throbbing ___ Burning ___ Pins/Needles ___ Shooting ____ If shooting to where? _____
2. Rate your pain (0=none) to (10=worse possible) _____
3. Can you do your daily activities? Yes ____ No _____
   (Describe any you cannot do) _____
4. Have you had X-rays, MRI or CT scan? Yes____ No ____ Date(s) taken _____ What areas were they taken? _____
5. Results: _____
6. Height _____ Weight _____
7. List all current medications: _____
   _____
8. List all current supplement: _____
   _____

Please check all of the following that apply to you:

__ History of Recent infection
__ Recent Fever
___ Arthritis
__ Diabetes
__ Corticosteroid use (steroid Inhaler)
__ Birth Control Pills
__ High Blood Pressure
__ Stroke (Date) ____
__ Dizziness/Fainting
__ Numbness in Groin/Buttocks
__ Urinary Retention
__ Aortic Aneurysm
__ Cancer/Tumor
__ Osteoporosis

___ Prostate Problem
___ Frequent Urination
___ Pregnancy, # of births ___
___ Abnormal Weight __ Gain __ Loss
___ Epilepsy/Seizures
___ Visual Disturbances
___ History of Low/mid back pain
___ History of Neck Pain
___ HIV/AIDS
___ Gastro-intestinal Issues
___ History of Alcohol use # ____ day/week
___ History of Tobacco use # _____ day/week
___ Surgeries _____
_____

Allergies: _____

Current daily work activities: ____ Sit more than stand ___ Stand more than sit ___ Stand/sit equally

Exercise habits: ___None ___Regular program ___ Semi regular program: Describe _____
_____