Symptom survey

Name: ________________________________

1. Check area where symptoms are present:
   - Neck
   - Elbow/Forearm
   - Upper Back
   - Thigh/Knee
   - Fingers
   - Shoulder
   - Hand/Wrist
   - Low Back
   - Lower Leg
   - Ankle/Foot

2. Please put a check by the word(s) that best describe your symptoms:
   - Aching/Cramp
   - Numbness/Tingling
   - Stiffness
   - Burning
   - Pain
   - Weakness
   - Loss of Color
   - Swelling
   - Other

3. When did you first notice the problem? _______ number of months -or- _______ years ago

4. How long does each episode last? (please check)
   - less than 1 hour
   - 1 hour to 24 hours
   - 24 hours to 1 week
   - 1 week to 1 month
   - 1 month to 6 months
   - more than 6 months

5. How many separate episodes have you had in the last year? ____________________________

6. What do you think caused the problem? _______________________________________________

7. Have you had the problem in the last 7 days?    ☐ Yes    ☐ No

8. How would you rate this problem? Mark an X on the line.
   
   RIGHT NOW:   None ____________________________ Unbearable
   AT ITS WORSE: None ____________________________ Unbearable

9. Have you had medical treatment for this problem?    ☐ Yes    ☐ No
   If yes, what was the diagnosis? ____________________________

10. How much time have you lost from work in the last year because of this problem? _____ days

11. How many days in the last year were you on modified duty because of this problem? _____ days

12. Have you changed jobs because of this problem?    ☐ Yes    ☐ No

13. Please comment on what you think would improve your symptoms: _______________________
    __________________________________________________________________________
Date ___ / ___ / ___

Work Location ____________________  Job ____________________

Phone ________  Work Hours ________  Supervisor ________________

Time on THIS job:

☐ Less than 3 months  ☐ 3 months to 1 year

☐ Greater than 1 year to 5 years  ☐ Greater than 5 years to 10 years

☐ Greater than 10 years

Have you had any pain or discomfort during the last year?

☐ Yes  ☐ No (If NO, skip to next page)

If YES, please shade in the area of the drawings below which bothers you the MOST: