SOUL CHIRO

SYMPTOM SURVEY

PATIENT INFORMATION

Today's Date: _____

Patient Name: _____

PHYSICAL SYMPTOMS

Check off all of the following physical symptoms/health issues that apply:

- ☐ Low Back Pain
- ☐ Sciatica
- ☐ Disc Herniation
- ☐ Headaches/Migraines
- ☐ Mid Back Pain
- ☐ Pain/Tension/Numb
- ☐ Fibromyalgia
- ☐ Head Injury
- ☐ Neck Pain
- ☐ Shoulders
- ☐ Arms
- ☐ Arthritis
- ☐ Sports Injury
- ☐ Hip Pain
- ☐ Legs
- ☐ Hands
- ☐ Menstrual Cramps
- ☐ Motor Vehicle Accident

Which of the above bothers you most? _____

How long have you been bothered by this condition? _____

CONDITIONS

Check off all of the following conditions you are experiencing or have experienced:

- ☐ High Blood Pressure
- ☐ Cancer
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Insomnia/Sleep Problems
- ☐ Menopausal Symptoms
- ☐ Asthma
- ☐ Ringing in Ears
- ☐ Fatigue
- ☐ PMS/Irritability
- ☐ Diabetes
- ☐ Sinus Problems
- ☐ Digestive Trouble
  - ☐ Constipation
  - ☐ Diarrhea
  - ☐ Gas
  - ☐ Bloating
  - ☐ Heart Burn
- ☐ Hormonal Imbalance
  - ☐ Infertility
  - ☐ Sexual Dysfunction
  - ☐ Bladder Trouble
- ☐ Dizziness
  - ☐ Nervousness
  - ☐ Stress/Anxiety
  - ☐ Depression
- ☐ Allergy
  - ☐ Weight Trouble
  - ☐ Thyroid Disorder
  - ☐ Other

_____

_____

Which of the above is your biggest concern? _____

How long have you been experiencing this condition? _____

OTHER

Please let us know if we have missed something you would like to share:

_____

_____

AFFECTS

Do these problems affect your ability to enjoy work? Yes ☐ No ☐

Do these problems affect your ability to enjoy family and friends? Yes ☐ No ☐

Do these problems affect your ability to sleep? Yes ☐ No ☐

If you checked any of the above items, you could be suffering from:

- **Undetected Nerve Damage**
- **Destructive Effects of Stress**
- **Autonomic Imbalance**

_____ _____

Signature of Patient Date Signed