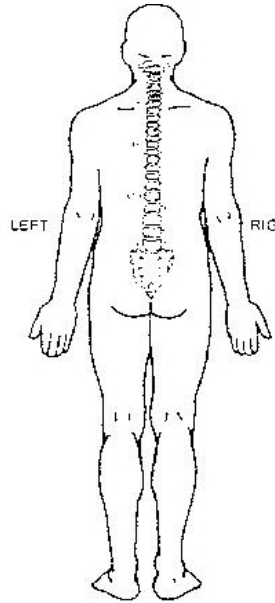


# TOLMAN CHIROPRACTIC

4645 S. Midland Dr., West Haven, UT 84401

## Symptom Rating Scale



LEFT                      RIGHT

**SEVERITY OF PAIN**  
List region of pain and circle severity number. [1 = least, 10 = greatest]

ex. Neck  
1 2 3 4 5 6 7 8 9 10

**MARK PAIN AREA**  
+++ Burning  
OOO Stabbing  
--- Sharp  
III Constant

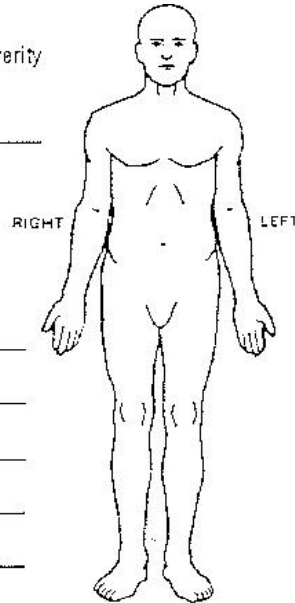
1. \_\_\_\_\_  
1 2 3 4 5 6 7 8 9 10

2. \_\_\_\_\_  
1 2 3 4 5 6 7 8 9 10

3. \_\_\_\_\_  
1 2 3 4 5 6 7 8 9 10

4. \_\_\_\_\_  
1 2 3 4 5 6 7 8 9 10

5. \_\_\_\_\_  
1 2 3 4 5 6 7 8 9 10



RIGHT                      LEFT

Please mark area of pain on the drawing using the code listed above.

Are there other areas of complaint? \_\_\_\_\_, \_\_\_\_\_  
1 2 3 4 5 6 7 8 9 10      1 2 3 4 5 6 7 8 9 10

Please check the following that apply to you, **P**ast or **C**urrent:

- |   |   |  |  |
|---|---|--|--|
| <p><b>P/C</b></p> <input type="checkbox"/> Headaches<br><input type="checkbox"/> Neck Pain/Stiffness<br><input type="checkbox"/> Mid Back Pain<br><input type="checkbox"/> Low Back Pain<br><input type="checkbox"/> Jaw Pain<br><input type="checkbox"/> Fatigue<br><input type="checkbox"/> Tension<br><input type="checkbox"/> Forgetfulness<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Allergy _____<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Restlessness<br><input type="checkbox"/> Night Sweats<br><input type="checkbox"/> Fainting<br><input type="checkbox"/> Palpitations | <p><b>P/C</b></p> <input type="checkbox"/> Ringing/buzzing in ears<br><input type="checkbox"/> Sleeping Problems<br><input type="checkbox"/> Loss of Memory<br><input type="checkbox"/> Stomach Pain/upset<br><input type="checkbox"/> Shortness of Breath<br><input type="checkbox"/> Nervousness/Anxiety<br><input type="checkbox"/> Chest Pain<br><input type="checkbox"/> Difficulty Concentrating<br><input type="checkbox"/> Dizziness/Loss of Balance<br><input type="checkbox"/> Nausea/Vomiting<br><input type="checkbox"/> Eyes Sensitive to Light<br><input type="checkbox"/> Sinus Pain<br><input type="checkbox"/> Ear aches/Infections<br><input type="checkbox"/> Fluid Retention<br><input type="checkbox"/> Varicose Veins | <p><b>P/C</b></p> <input type="checkbox"/> Head Feels Heavy<br><input type="checkbox"/> Loss of Smell/Taste<br><input type="checkbox"/> Numbness/Weak Legs/Feet<br><input type="checkbox"/> Numbness/Weak Arms/Hands<br><input type="checkbox"/> Pins & Needles Arms/Hands<br><input type="checkbox"/> Pins & Needles Legs/Feet<br><input type="checkbox"/> Shoulder/Arm/Wrist Pain<br><input type="checkbox"/> Hip/Leg/Knee/Ankle Pain<br><input type="checkbox"/> Diarrhea<br><input type="checkbox"/> Constipation<br><input type="checkbox"/> Hemorrhoids<br><input type="checkbox"/> Pain in Eyes<br><input type="checkbox"/> Hives/Allergy Rash<br><input type="checkbox"/> Gout<br><input type="checkbox"/> Muscle Cramps | <p><b>P/C</b></p> <input type="checkbox"/> Eczema<br><input type="checkbox"/> Bruise easily<br><input type="checkbox"/> Blood in Urine<br><input type="checkbox"/> Blood in Stool<br><input type="checkbox"/> Painful Urination<br><input type="checkbox"/> Bed wetting<br><input type="checkbox"/> Kidney Infection<br><input type="checkbox"/> Other _____ <p><b>Women Only</b></p> <input type="checkbox"/> Irregular cycles<br><input type="checkbox"/> Cysts/Polyps/Fibroids<br><input type="checkbox"/> Painful periods<br><input type="checkbox"/> Hot Flashes<br><input type="checkbox"/> Last Pap Smear _____ |
|---|---|--|--|

(**P**=Personal/**F**=Family History)

- |   |  |   |  |
|---|--|---|--|
| <p><b>P/F</b></p> <input type="checkbox"/> Osteoporosis<br><input type="checkbox"/> Heart Disease<br><input type="checkbox"/> Vascular Disorders<br><input type="checkbox"/> Diabetes | <p><b>P/F</b></p> <input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Inflammatory Disease<br><input type="checkbox"/> Arthritis/Joint Disease<br><input type="checkbox"/> Stroke | <p><b>P/F</b></p> <input type="checkbox"/> Genetic Disease<br><input type="checkbox"/> Congenital Disorder<br><input type="checkbox"/> Infectious Disease<br><input type="checkbox"/> Scoliosis | <p><b>P/F</b></p> <input type="checkbox"/> Mental Illness<br><input type="checkbox"/> Cancer _____<br><input type="checkbox"/> Other _____ |
|---|--|---|--|

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_