a. When did your symptoms start? b. What caused your symptoms to begin?  (Mark areas involved)  2. How often do you experience your symtoms?  Constantly (76-100% of the day)  Frequently (51-75% of the day)  Occasionally (26-50% of the day)  Intermittently (0-25% of the day)  3. What describes the nature of your symptoms?  sharp shooting stiff/sore dull ache burning tense/tight  4. How are your symptoms changing? Getting better Not changing Getting  What makes your symptoms worse?  What makes your symptoms better?  5. Circle the lowest and highest levels of symptoms:(None) 0 1 2 3 4 5 6 7 8 9 10 (W.  3. a. Are you pregnant? Yes No Not sure  b. Please list the medications or supplements you are currently taking.  c. Do you smoke? Yes No Previously  d. Allergies: Environmental Medication  Food  e. Do you drink alcohol, coffee, pop? If so, how many per day?  7. Who have you seen for your symptoms?  No one chiropractor medical doctor physical therapist of the pheart or blood pressure gastrointestinal graph or the problems such as	. Describe				54.6
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