Sterling Osteopathic & Wellness Care

Name: _____DOB: _____Date:_____

Major concerns:

_____

_____

Major improvements: _____

_____

Supplements_____

_____

Please place check mark based upon symptoms since last visit (0 = no symptoms, 5 = worst symptoms ever)

Fever	0 1 2 3 4 5
Fatigue	0 1 2 3 4 5
Night Sweats	0 1 2 3 4 5
Pain	0 1 2 3 4 5
Headache	0 1 2 3 4 5
Palpitations	0 1 2 3 4 5
Swollen Glands	0 1 2 3 4 5
Neck pain	0 1 2 3 4 5
Shortness of Breath	0 1 2 3 4 5
Abdominal pain	0 1 2 3 4 5
Diarrhea	0 1 2 3 4 5
Muscle aches	0 1 2 3 4 5
Muscle spasm	0 1 2 3 4 5
Low back pain	0 1 2 3 4 5
Knee pain	0 1 2 3 4 5
Joint pain	0 1 2 3 4 5
Numbness	0 1 2 3 4 5
Dizziness	0 1 2 3 4 5
word find issues	0 1 2 3 4 5
Brain fog	0 1 2 3 4 5
Depression	0 1 2 3 4 5
Anxiety	0 1 2 3 4 5
Rash	0 1 2 3 4 5

Draw Painful Areas

Place an x or dot below and click submit
or print & bring it with you to your visit