Additional Symptoms

Select the region, it's applicable subregion/extremity and any additional applicable information per injury/symptom you may be experiencing.

Symptom # _____

Region **-- Select Region** **-- Select Right/Left/Both**

Subregion/Extremity **-- Select Upper Extremity** **-- Select Abdomen Region** **-- Select Lower Extremity**

Check Injuries & Symptoms that apply:

- ☐ **Cuts**
- ☐ **Burns**
- ☐ **Bruises**
- ☐ **Scrapes, scratches or abrasions**
- ☐ **Stiffness or tightness**
- ☐ **Swelling**
- ☐ **Difficulty Talking**
- ☐ **Difficulty Eating**
- ☐ **Difficulty Swallowing**
- ☐ **Back pain**
- ☐ **Chest Pain**
- ☐ **Mouth injury, including teeth**
- ☐ **Head pain (not headache)**
- ☐ **Headache pain**
- ☐ **Muscle pain**
- ☐ **Neck pain**
- ☐ **Radiating pain**
- ☐ **Ringing in ears**
- ☐ **Light sensitivity**
- ☐ **Spine pain in Selected Region**
- ☐ **Noise sensitivity**
- ☐ **Vision changes**
- ☐ **Change in normal ability to smell**

Check Sides that apply: ☐ **All Sides**

☐ **Front Side** ☐ **Back Side** ☐ **Left Side** ☐ **Right Side** ☐ **Top of Head** ☐ **Left & Right** ☐ **Front & Back**

How frequently does this occur? ☐ **Constantly** ☐ **Hourly** ☐ **Daily** ☐ **Weekly** ☐ **Monthly**

How long does this last? _____ **-- Select Duration Typ**

I find relief by **using ice, taking meds, stretching, resting, using heat, etc.**

Additional Symptoms

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Symptom # _____

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☐ Stiffness or tightness	☐ Swelling	☐ Difficulty Talking	☐ Difficulty Eating
☐ Difficulty Swallowing	☐ Back pain	☐ Chest Pain	☐ Mouth injury, including teeth
☐ Head pain (not headache)	☐ Headache pain	☐ Muscle pain	☐ Neck pain
☐ Radiating pain	☐ Ringing in ears	☐ Light sensitivity	☐ Spine pain in Selected Region
☐ Noise sensitivity	☐ Vision changes	☐ Change in normal ability to smell	

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