HEALTH CONCERNS SYMPTOMS QUESTIONNAIRE

1. What **main problem** brings you to the clinic?

   ____

2. How **long** have you had this problem?

   ____

3. Have you seen a doctor for this problem before? ❑ Yes ❑ No

4. Are you **worried** something **serious** might be causing the problem? ❑ Yes ❑ No

5. What do you think might be causing the problem?

   ____

   ____

6. Check all items you hope the doctor might do about your problem?
   - ❑ Explain what is causing my problem
   - ❑ Tell me how long my problem is likely to last
   - ❑ Prescribe a medicine
   - ❑ Order some lab tests or X-rays
   - ❑ Refer me to another clinic or specialist
   - ❑ Give me a sick slip
   - ❑ Other (please list) ____

7. Circle the number that best describes the amount of **stress** you've been experiencing lately, from 10 (unbearable) to 0 (none at all).

   (Unbearable) 10 9 8 7 6 5 4 3 2 1 0 (None at all)

8. In general, would you say your health is:

   ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

9. Circle the number that best describes **how bad** your **problem or symptom** is, from 10 (unbearable) to 0 (none at all).

   (Unbearable) 10 9 8 7 6 5 4 3 2 1 0 (None at all)

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