Signs and Symptoms Journal Entry

Name: ______________________________ Date: ____________________

Main problem (include location): ____
____

Signs (bruises, cuts, swelling, blood in feces, deformities, etc): ____
____

What you were doing when it started: ____
____

What makes it better/worse: ____
____

Describe the symptom (circle all that apply): constant intermittent 1-time only

hot	sharp	piercing	burning	throbbing	shooting
cool	dull	stabbing	aching	pressure	cutting

Other: ____

Does it stay in one place (circle one): Yes No

If No, where else do you feel it: ____

On a scale from 0 to 10, where 0 is no pain at all and 10 is the worst pain you could possibly imagine, rate the following:

When the problem began: 0 1 2 3 4 5 6 7 8 9 10

Average pain: 0 1 2 3 4 5 6 7 8 9 10

Current pain: 0 1 2 3 4 5 6 7 8 9 10

When problem began: ____

How long does it last (chose 1): ___ minutes _____ hours _____ days _____weeks ___months

___ years Other: ____

What have you done for the problem (ice, pain reliever, massage, change diet, etc) and what effects did it have:
____
____
____

Other things going on in your life (stress, job, divorce, new diet, etc): ____
____
____

Copy and give to your PA or doctor

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