

Today's date \_\_\_\_\_

## **New Symptom or Condition Form**

**What is your new symptom or new health condition?**

---

**When did it start (approximate date)?** \_\_\_\_\_

**What does it feel like?**

---

**Have you ever had something like this in the past?**

---

**What are you most concerned it may be?**

---

**What daily activities have you had trouble doing since it started?**

---

**What changes have you made to try to make it better (diet, activity, stress reduction)?**

---

**What medicines or treatments (such as heat, ice, massage) have you used to try to make it better?**

---

**What brings on the symptom or makes it worse?**

---

**How often do you have the symptom?** \_\_\_\_\_

**How long does it last when you have it?** \_\_\_\_\_