BECOMING HealthyHer

PREPARE | PRESENT | PREVENT

DESCRIBE YOUR CONCERN

WHERE ARE YOUR SYMPTOMS LOCATED?

WHEN DID IT START? (DATE OR TIME FRAME?)

HOW DOES IT FEEL? (CHECK ALL THAT APPLY)

- ☐ Sharp
- ☐ Burning
- ☐ Throbbing
- ☐ Comes and goes
- ☐ Pulsing
- ☐ Irritating
- ☐ Aching
- ☐ Cramping
- ☐ Dulll
- ☐ Tingling
- ☐ Numbness
- ☐ Tightness
- ☐ Constant
- ☐ Other (please describe):

WHAT MAKES IT WORSE?

e.g., sitting, standing, movement, eating, stress

WHAT MAKES IT BETTER?

e.g., heat, rest, ibuprofen, stretching

HOW IS THIS IMPACTING YOUR DAILY LIFE?

e.g., sleep, work, exercise, caregiving, school, relationships

HOW OFTEN DOES THIS HAPPEN?

- ☐ Constantly
- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Daily
- ☐ Occationally

ON A SCALE OF 1–10, HOW SEVERE ARE YOUR SYMPTOMS?

HAVE YOU TRIED ANY METHODS TO HELP YOUR SYMPTOMS?

e.g., medication, rest, exercise, ice, heat, supplements