Patient Name: _____ **Date of Birth:**_____

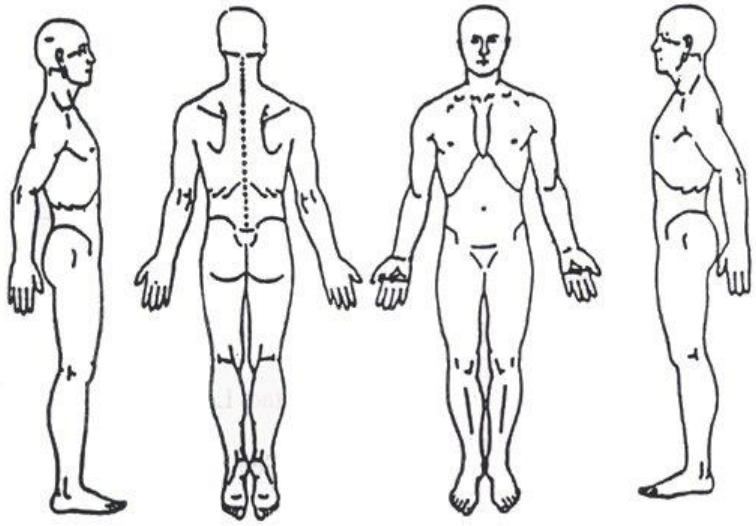
History of Illness / Injury / Pain

CHIEF COMPLAINT & LOCATION

Chief Complaint and its location: _____

When did the pain start? _____ What caused the pain? _____

Please put an "X" on ALL spots you are experiencing pain



How often do you experience this pain?

☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional

SEVERITY

On a scale of 0 to 10 with 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain.

0 = None 1 = Minimal 2 = Very Mild 3 = Moderate 4 = Mild to Moderate 5 = Moderate 6 = Moderate to Severe
7 = Mildly Severe, Restricts some activity 8 = Severe, limits most activity 9 = Very Severe 10 = Excruciating

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10? _____
What is the least intense pain the symptom has been on a scale of 0 to 10? _____
What is the most intense the symptom has been on a scale of 0 to 10? _____

ASSOCIATED SIGNS & SYMPTOMS

How does this symptom affect your movement?

☐ Inflexibility ☐ Spasms ☐ Other:_____
☐ Stiffness ☐ Cramps _____

QUALITY

How would you best describe the sensation of the pain/symptom?

☐ Deadness ☐ Stabbing ☐ Burning ☐ Sharp
☐ Prickly ☐ Hurting ☐ Shooting ☐ Aching
☐ Numb ☐ Pulsating ☐ Throbbing ☐ Excruciating
☐ Crawling ☐ Pins & Needles ☐ Stinging
☐ Tingling ☐ Pounding ☐ Dull

Patient Signature: _____ **Todays' Date:** _____

Patient Name: _____ **Date of Birth:**_____

Does this pain radiate or travel? **YES / NO**
If YES, where to? _____

MODIFYING FACTORS
What aggravates the pain/symptom?

- ☐ Sitting
- ☐ Standing
- ☐ Sneezing
- ☐ Lifting
- ☐ Pushing
- ☐ Walking
- ☐ Climbing Stairs
- ☐ Exercising
- ☐ Repetitive movement
- ☐ Looking up & down
- ☐ Looking side/side
- ☐ Coughing
- ☐ Getting in/out of car
- ☐ Driving
- ☐ Getting out of bed
- ☐ Pulling
- ☐ Carrying
- ☐ OTHER: _____ _____ _____ _____ _____

What relieves the pain/symptom? _____
Over the past weeks/months this complaint is:

- ☐ Improving
- ☐ Getting worse
- ☐ About the same

Have you seen anyone for this condition? **YES / NO** If YES, Whom?: _____

Have you ever had any of the following?

Medical Problem(s)	YES	NO	If Yes, Explain
Allergies (Food, Medication, Etc.)			
Angina / Chest Pain			
Arthritis			
Asthma			
Broken Bones			
Cancer			
Diabetes			
Gout			
Heart Disease			
HIV			
Permanent Disabilities			
Stroke			
Thyroid Problems			
Other MAJOR Past Medical History to Note:			

Patient Name: _____ Date of Birth:_____

What Medications are you currently taking?_____

_____

_____

Have you had any of the following surgeries?

SURGERY	Yes	No	Year	SURGERY	Yes	No	Year	SURGERY
Appendix				MEN				OTHER
Colon				Prostate				
Gall Bladder				WOMEN				
Heart				Breast				
Hernia				Ovaries				
Kidney				Uterus				
Stomach								
Tonsils								

Any other MAJOR injuries, surgeries, or hospitalizations to note? _____

_____

_____

_____

Do you have a pace maker? YES / NO Are you pregnant? YES / NO Do you think you might be pregnant? YES / NO

Who is your primary care physician?_____

Marital Status (Circle one): Single / Married / Divorced / Separated / Widowed

Spouse's Name: _____ Spouses' Birthdate: _____

Do you have any children? YES / NO If YES, how many? _____

How often do you exercise?

☐ Never ☐ Occasionally ☐ Regularly
☐ Rarely ☐ Moderately

Intensity of Exercise:

☐ Low Level ☐ High Level
☐ Medium Level ☐ Competition Level

Sufficient Rest:

☐ Never ☐ Rarely ☐ Occasionally ☐ Moderately

Average Hours of Sleep per Night:

☐ 1 – 3 ☐ 3-6 ☐ 6-8 ☐ 8+

Well Balanced Diet:

☐ Never ☐ Rarely ☐ Occasionally ☐ Moderately

Patient Signature: _____ Todays' Date: _____

Patient Name: _____ Date of Birth:_____

Are you a current smoker? (Circle One) - YES / NO **Are you a former Smoker? (Circle One) – YES / NO**

If YES, how many packs per week?:

☐ 0 to 1 ☐ 1 to 2 ☐ 3+

Describe your Alcohol consumption:

☐ Daily ☐ Monthly ☐ Rarely
☐ Weekly ☐ Occasionally ☐ Never

Have you ever used illicit drugs? YES / NO

Hobbies: _____

Are you experiencing any other pain in a different area? **YES / NO**

If YES, explain what areas & type of pain: _____

_____

_____

_____

_____

_____

_____

---------- **OFFICE USE ONLY** ----------

Notes: _____

_____

_____

_____

_____

_____

_____

Patient Signature: _____ Todays' Date: _____