Date:_____

PATIENT'S PRESENT COMPLAINT

Name:_____ **Sex:** Male/Female **Age:** _____

Please check all answers and fill in the blanks where appropriate. Describe your present complaint.
This information is necessary to assist your health care provider understand your health condition.

Please describe your present complaint and how it began. **Date of onset:**_____/_____/_____

_____

_____

_____

How bad is your pain (circle a number or range) **0 1 2 3 4 5 6 7 8 9 10**
No Pain **Undearable pain**

How often are symptoms present? ☐ Constant 100%-76% ☐ Frequent 75%-51% ☐ Occasional 50%-26% ☐ Intermittent 25%-1%

Describe your present pain/symptoms.	☐ Sharp/Stabbing	☐ Throbbing	☐ Aches
	☐ Dull	☐ Sore	☐ Weakness
	☐ Numbness	☐ Shooting	☐ Gripping
	☐ Tingling	☐ Burning	☐ Other_____
Since it began is your problem?	☐ Improving	☐ Getting Worse	☐ No Change
What makes the problem better?	☐ Nothing	☐ Lying Down	☐ Walking
	☐ Standing	☐ Sitting	☐ Movement
	☐ Exercise	☐ Inactivity/Rest	☐ Other _____
What makes the problem worse?	☐ Nothing	☐ Lying Down	☐ Walking
	☐ Standing	☐ Sitting	☐ Movement
	☐ Exercise	☐ Inactivity/Rest	☐ Other _____
Can you perform your daily home activities?	☐ Yes, all activities	☐ Only with help	☐ Not at all
Can you perform your daily work activities?	☐ Yes, all activities	☐ Only with help	☐ Not at all
Describe your job requirements.	☐ Mainly sitting	☐ Light labor	☐ Heavy labor
Do you exercise?	☐ Almost Daily	☐ Occasionally	☐ Not at all
Describe your stress level.	☐ None to mild	☐ Moderate	☐ High

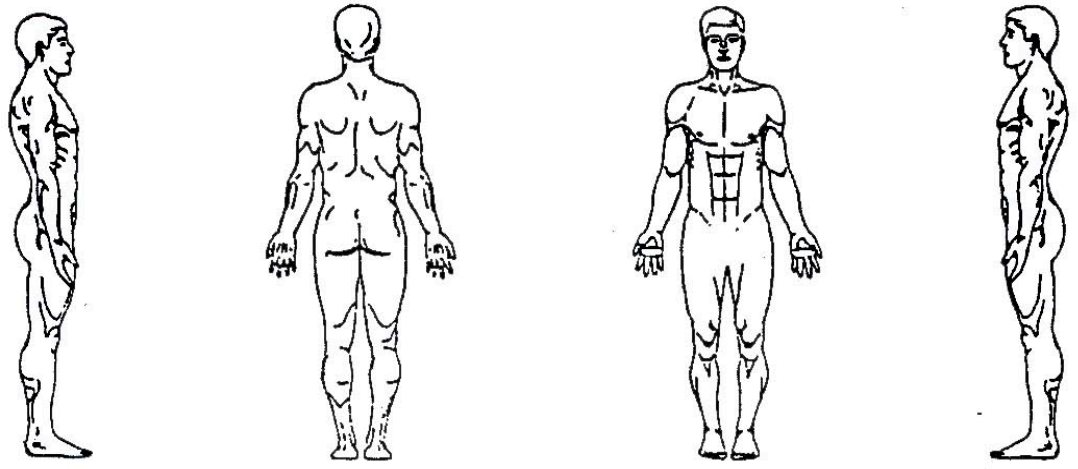
What treatment have you had for this condition in the past? (surgery, medication, injections, therapy, chiropractic)

_____

Have you had X-Rays, MRI, or other tests for this condition? What Tests and When? _____

_____

Mark An X on the picture where you have pain or other symptoms including numbness and tingling.



If you have ever had a listed symptom in the past, please check that symptom in the **Past Column**. If you are presently having a symptom, check that symptom in the **Present Column**. Knowledge of these conditions may influence the type of treatment/therapy you receive.

Past	Present	Condition	Past	Present	Condition
☐	☐	Neck Pain	☐	☐	Depression
☐	☐	Shoulder Pain (R____ L____)	☐	☐	Aortic Aneurysm
☐	☐	Pain in upper arm or elbow (R____ L____)	☐	☐	High Blood Pressure
☐	☐	Hand Pain (R____ L_____)	☐	☐	Angina
☐	☐	Wrist Pain (R____ L_____)	☐	☐	Heart Attack(date)___/___/__
☐	☐	Upper Back Pain	☐	☐	Stroke(date) ___/___/___
☐	☐	Low Back Pain	☐	☐	Asthma
☐	☐	Pain in Upper Leg Hip(R___ L___)	☐	☐	Cancer, Explain_____
☐	☐	Pain in Lower Leg Knee (R___ L___)	☐	☐	Tumor, Explain _____
☐	☐	Pain in Foot or Ankle (R___ L___)	☐	☐	Prostate Problems
☐	☐	Jaw Pain	☐	☐	Blood Disorder
☐	☐	Swelling, Stiffness of Joints	☐	☐	Emphysema(chronic lung disorder)
☐	☐	Fainting	☐	☐	Arthritis
☐	☐	Visual Disturbance	☐	☐	Rheumatoid Arthritis
☐	☐	Convulsions	☐	☐	Diabetes
☐	☐	Dizziness	☐	☐	Epilepsy
☐	☐	Headaches	☐	☐	Ulcer
☐	☐	Muscular in coordination	☐	☐	Liver/Gallbladder problems
☐	☐	Tinnitus (Ear Noises)	☐	☐	Kidney Stones
☐	☐	Rapid Heart Beat	☐	☐	Kidney Disease _____
☐	☐	Chest Pain	☐	☐	Bladder Infection
☐	☐	Loss of Appetite	☐	☐	Hepatitis _____
☐	☐	Anorexia	☐	☐	Colitis
☐	☐	Abnormal Weight Gain	☐	☐	Irritable Bowl/Colon
☐	☐	Abnormal Weight Loss	☐	☐	HIV/AIDS
☐	☐	Excessive Thirst	☐	☐	Chronic Cough
☐	☐	General Fatigue	☐	☐	Chronic Sinusitis
☐	☐	Loss of Bladder Control	☐	☐	Difficulty Swallowing
☐	☐	Dermatitis/Eczema/Rash	☐	☐	Heartburn/Indigestion
☐	☐	Painful Urination	☐	☐	Abdominal Pain
☐	☐	Frequent Urination	☐	☐	Constipation/Irregular Bowl
☐	☐	Other _____			
Females					
☐	☐	Irregular Menstrual Flow	☐	☐	Breast ☐ Soreness, ☐ Lumps
☐	☐	Endometriosis	☐	☐	PMS
☐	☐	Pregnancy, # Births _____	☐	☐	Birth Control Pills, Type_____

Hospitalizations/Surgical Procedures (List if not listed elsewhere _____

_____

Family History

☐ Rheumatoid Arthritis	☐ Diabetes	☐ Heart Condition	☐ Lung Condition
☐ Epilepsy	☐ Chronic Back Problems	☐ Chronic Headaches	☐ Lupus
☐ High Blood Pressure	☐ Cancer	☐ Other _____	

Social History

Past	Present	
☐	☐	Tobacco; # Day_____
☐	☐	Alcohol; # Day _____
☐	☐	Drug or Alcohol Dependence
☐	☐	Coffee/Tea/Caffeinated Soft Drinks; # Day_____

Disability Rating

Do you have a disability rating?
Date Received ____/____/____
Rating Percentage _____%
Location _____

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify the doctor immediately whenever I have a change in my health condition or health plan coverage in the future,

Name:_____

Patient's Signature Date