

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										Unbearable 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 _____

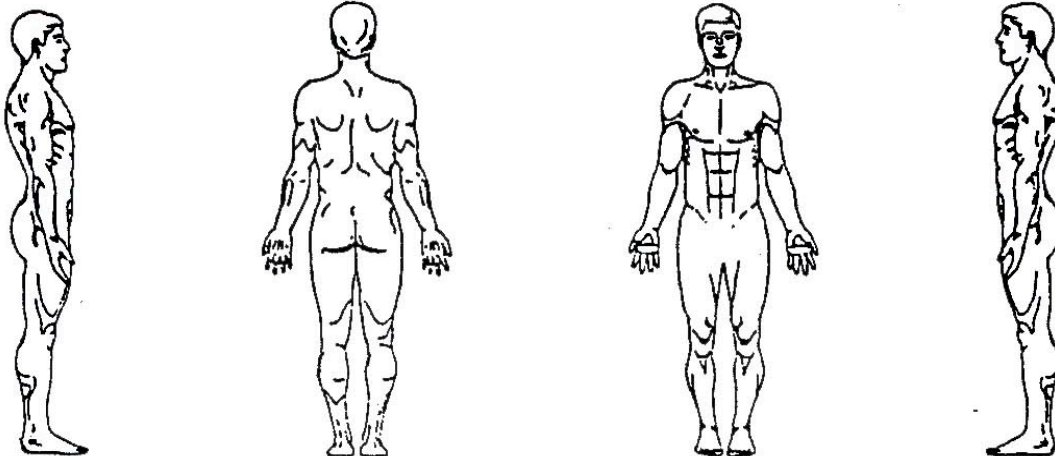
What makes the problem worse? Nothing Lying Down Walking
 Standing Sitting Movement
 Exercise Inactivity/Rest Other _____

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

Hospitalizations/Surgical Procedures (List if not listed elsewhere) _____

Family History

<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Lung Condition
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Chronic Back Problems	<input type="checkbox"/> Chronic Headaches	<input type="checkbox"/> Lupus
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cancer	<input type="checkbox"/> Other _____	

Social History

Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Tobacco; # Day _____
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol; # Day _____
<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/>	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,

Patient's Signature

Date