

NAME: _____ DATE ____/____/____ Account#: _____

HISTORY OF ILLNESS / INJURY / PAIN

LOCATION

Chief complaint and it's location: _____

What caused the onset?: _____

Date of onset?: ____/____/____

TIMING AND DURATION

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 = Mild	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?

____0 ____1 ____2 ____3 ____4 ____5 ____6 ____7 ____8 ____9 ____10

What is the least intense the symptom has been on a scale of 0 to 10?

____0 ____1 ____2 ____3 ____4 ____5 ____6 ____7 ____8 ____9 ____10

What is the most intense the symptom has been on a scale of 0 to 10?

____0 ____1 ____2 ____3 ____4 ____5 ____6 ____7 ____8 ____9 ____10

ASSOCIATED SIGNS AND SYMPTOMS

How does this symptom affect your movement? ____ Inflexibility ____ Stiffness ____ Spasms ____ Cramps

Other: _____

QUALITY

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

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

ADDITIONAL ASSOCIATED SIGNS & SYMPTOMS

If this pain/symptom radiates or travels, please identify where to: _____

MODIFYING FACTORS

What aggravates the pain/symptom?

- | | | | | |
|-------------------------|----------------------|----------------------|------------------------|----------------------------|
| ____ Flashing lights | ____ Sneezing | ____ Lifting | ____ Exercising | ____ Looking up/down |
| ____ Coughing | ____ Sitting | ____ Stooping | ____ Looking side/side | ____ Anger |
| ____ Standing | ____ Depression | ____ Stress | ____ Driving | ____ Walking |
| ____ Getting out of bed | ____ Pushing | ____ Emotional upset | ____ Pulling | ____ Repetitive movement |
| ____ Carrying | ____ Straining at BM | ____ Climbing stairs | ____ Walking up hill | ____ Getting in/out of car |

Other: _____

What relieves this pain/symptom?

- | | | | | | |
|------------------|---------------|--------------|--------------|-----------------|------------------------|
| ____ Resting | ____ Sleeping | ____ Cold | ____ Heat | ____ Sitting | ____ Exercise/Movement |
| ____ Shower | ____ Advil | ____ Aspirin | ____ Tylenol | ____ Pain pills | ____ Treatment |
| ____ Mineral ice | ____ Other | | | | |

Over the past weeks/months this complaint is: ____ Improving ____ Getting Worse ____ About the Same

Patient history was obtained from: ____ Patient ____ Father ____ Mother ____ Son ____ Daughter

Have you seen anyone for this condition? ____ YES ____ NO WHOM? _____

Do you have a pacemaker? ____ YES ____ NO	Are you Pregnant? ____ YES ____ NO
	Do you think you may be pregnant? ____ YES ____ NO

Doctor Signature _____

NAME: _____ DATE ____ / ____ / ____ Account#: _____

SECONDARY COMPLAINT & LOCATION

Location _____ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?
____ 0 ____ 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10
What is the least intense the symptom has been on a scale of 0 to 10?
____ 0 ____ 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10
What is the most intense the symptom has been on a scale of 0 to 10?
____ 0 ____ 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10

ASSOCIATED SIGNS AND SYMPTOMS

How does this symptom affect your movement? ____ Inflexibility ____ Stiffness ____ Spasms ____ Cramps

Other: _____

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

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

Over the past weeks/months this complaint is: ____ Improving ____ Getting Worse ____ About the Same

THIRD COMPLAINT & LOCATION

Location _____ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?
____ 0 ____ 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10
What is the least intense the symptom has been on a scale of 0 to 10?
____ 0 ____ 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10
What is the most intense the symptom has been on a scale of 0 to 10?
____ 0 ____ 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10

ASSOCIATED SIGNS AND SYMPTOMS

How does this symptom affect your movement? ____ Inflexibility ____ Stiffness ____ Spasms ____ Cramps

Other: _____

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

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

Over the past weeks/months this complaint is: ____ Improving ____ Getting Worse ____ About the Same

FOURTH COMPLAINT & LOCATION

Location _____ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?
____ 0 ____ 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10
What is the least intense the symptom has been on a scale of 0 to 10?
____ 0 ____ 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10
What is the most intense the symptom has been on a scale of 0 to 10?
____ 0 ____ 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10

ASSOCIATED SIGNS AND SYMPTOMS

How does this symptom affect your movement? ____ Inflexibility ____ Stiffness ____ Spasms ____ Cramps

Other: _____

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

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

Over the past weeks/months this complaint is: ____ Improving ____ Getting Worse ____ About the Same

Doctor Signature _____

NAME: _____ DATE ____/____/____ Account#: _____

PAST PROBLEMS, SURGERY, AND MEDICATIONS											
P	N	Past Problem				When and Explanation of Condition					
		Cancer									
		Balance problems									
		Stroke									
		Thyroid Problems									
		Asthma									
		Heart Attack									
		HIV									
		Angina/Chest Pain									
		Diabetes									
		Gout									
		Broken Bones									
		Arthritis									
		Serious Depression									
		Other									
		SURGERY	YES	NO	YEAR	SURGERY	YES	NO	YEAR		
		Tonsils				WOMEN					
		Colon				Breast					
		Hernia				Uterus					
		Appendix				Ovaries					
		Gall Bladder				MEN					
		Stomach				Prostate					
		Heart				Other					
		Kidney									
		Other									
		What other major injuries have you had? Date			Have you ever taken:		YES	NO	YEAR		
					Insulin						
					Cortisone						
					Thyroid Medicine						
					Male/Female Hormones						
		What medications are you currently taking? Date			Blood Pressure		YES	NO	YEAR		
					Tranquilizers/Sedatives						
					Birth Control						
Hospitalizations:											

Doctor Signature _____

NAME: _____ DATE ____/____/____ Account#: _____

Marital Status: _____ Married _____ Divorced _____ Single _____ Separated _____ Widowed

Number of Children: _____

Frequency of exercise: _____ Never _____ Rarely _____ Occasionally _____ Moderately _____ Regularly

Intensity of exercise: _____ Low Level _____ Medium Level _____ High Level _____ Competition Level

Sufficient rest: _____ Never _____ Rarely _____ Occasionally _____ Moderately

Hours of sleep: _____ 10 or more hours

Well balance diet: _____ Never _____ Rarely _____ Occasionally _____ Moderately

Do you Smoke?

_____ No _____ Occasionally _____ 1 to 2 _____ 2 to 3 _____ 4 to 5 _____ More than 5 packs/day

Do you drink caffeinated beverages?

_____ No _____ Occasionally _____ 1 to 2 _____ 2 to 3 _____ 4 to 5 _____ More than 5 drinks/day

Do you drink alcoholic beverages?

_____ No _____ Occasionally _____ 1 to 2 _____ 2 to 3 _____ 4 to 5 _____ More than 5 drinks/day

Have you ever used street drugs?

_____ Yes _____ NO

Hobbies:

How did you hear about us? _____

If from advertisement:

1. Newspaper Insert? _____ Which Newspaper? _____

2. Free Report? _____

3. Infomercial? _____

4. Decompression? _____

5. Other _____

Billboard? _____

Yellow Pages? _____

Website? _____

Family or Friend? _____

Monthly Newsletter? _____

Doctor Signature _____