

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please where your pain is and rate your pain on a scale from 1-10 with 10 being the worst.

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____

Syptoms are worse in: Morning Afternoon Night

When and How Injury Occurred?: _____

Syptoms Developed From: Illness Job Related Injury Auto Accident
 Unknown Cause Gradual Onset Other Accident

Date Occurred: _____

Syptoms Have Persisted For #:

_____ Hour(s) _____ Day(s) _____ Week(s) _____ Month(s) _____ Year(s)

Syptoms/Complaints: Come & Go Are Constant

Have You Ever Had This Before? No Yes

When?: _____

Name and Location of Doctor Previously Seen for Present Condition(s): _____

Are You Taking Any Medications? No Yes

What Kind?: _____

Are You Pregnant? No Yes

Date of Last Menstrual Period: _____

Please Check the Following Activities That Aggravate Your Condition: Bending
 Coughing Sitting Turning Head Lifting Standing
 Reaching Straining at Stool Sneezing Walking Lying Down

Please Check the Following Activities That Alleviate Your Condition:
 Sitting Turning Head Standing Walking Reaching
 Lifting Bending Lying Down

Please Check Any Additional Symptoms You Are Experiencing: Blurred Vision
 Cold Sweat Concentration Loss/ Confusion Constipation Diarrhea
 Fainting Fatigue Fever Heavy Head Headaches Insomnia
 Loss of Smell Loss of Taste Low Immune System Muscle Jerking
 Pins and Needles In Legs Ringing In Ears Shortness of Breath
 Cold Hands Cold Feet Buzzing In Ears Depression/ Weeping Spells
 Dizziness Stiff Neck Loss of Balance Light Sensitive Eyes
 Numbness In Fingers Pins and Needles In Arms

Patient's Signature: _____ Date: _____

