Name________________________ Date______________________

Chief Complaints

- What is your **major/presenting** complaint? (Please provide an exact description?

____
____
____
____
____

- Describe the **onset** of this condition. Is your complaint related to a fall, an accident, work injury or an auto accident? Please describe!

____
____
____
____

- How **long** have you had this condition? How **often** does it happen?

____
____
____
____

- Do you have a **history** of similar conditions in the past?

____
____
____

- Is the condition getting (please circle):
  Worse
  Same
  Better
  Consistent
  Recurring

- How does your condition interfere with your work or activities of daily living?

____
____
____
____

- How would you describe the pain that you are experiencing?

Persistent	Intermittent
Aching/Throbbing	Tingling
Numbness	Burning
Shooting Pain	Radiating
Other	

- What **helps/relieves** your condition?

____
____
____
____
____
____

- What **aggravates/worsens** your condition?

____
____
____
____
____

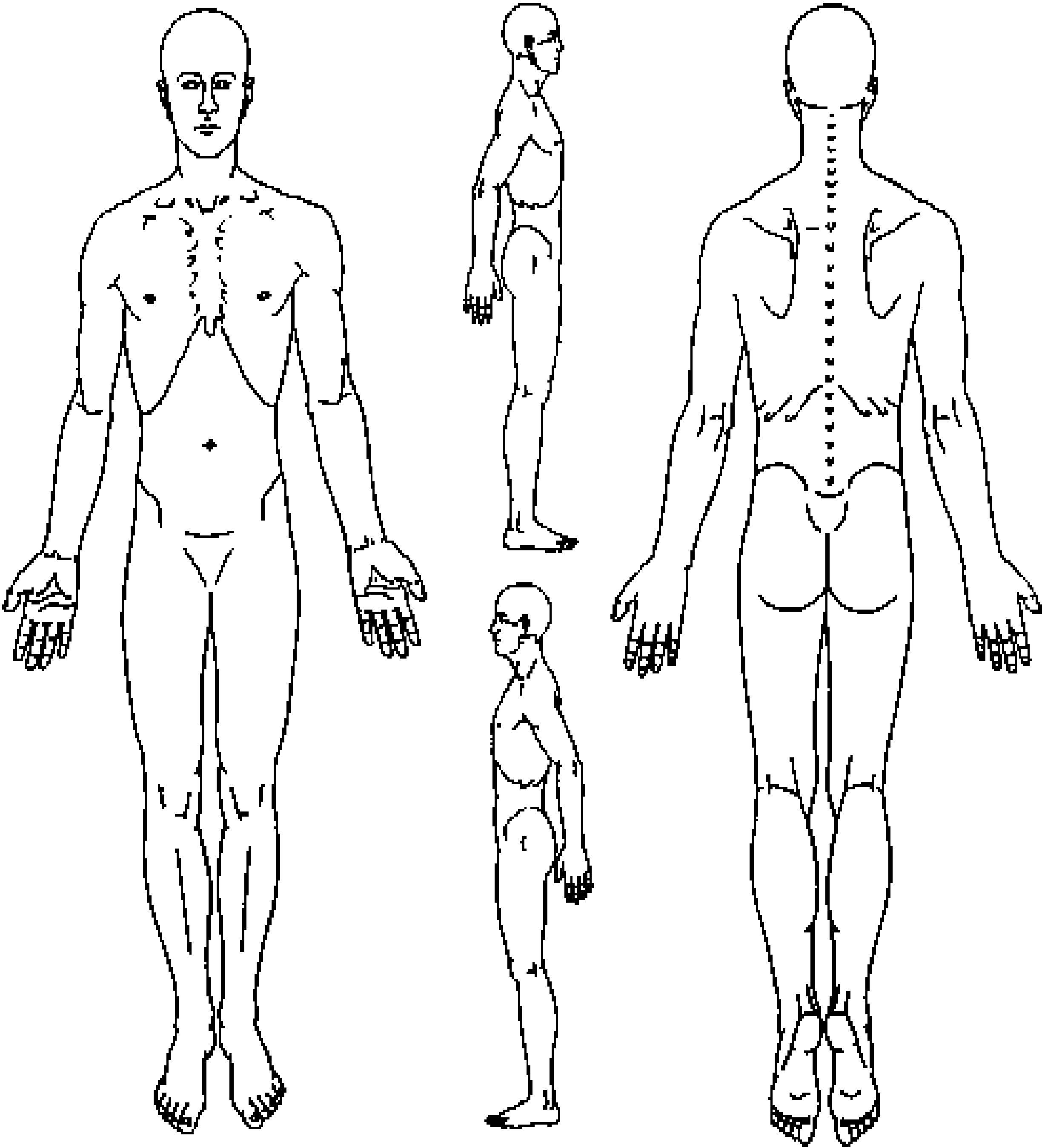
- Are there any other health issues or concerns you would like to discuss on this visit?

____
____
____
____

Please mark your symptoms on the diagram using the symbols below:

Numbness	Pins and Needles	Burning
IIIIIII	00000000	xxxxxxx

Stabbing	Ache
////////	>>>>>>



No Pain |——————————————————| Worst Pain

Please mark on the line above, where you would describe your pain level today