

PATIENT HISTORY/EXAMINATION FORM

Complete ALL questions below

1. What are your **major complaint(s)/illnesses**? _____

2. What are your **minor complaint(s)/illnesses**? _____

3. How **long** have you been experiencing your major complaint? Days Weeks Months Years

Mechanism of Injury

4. What was the **cause** of your major complaint that brought you into the office today(how did it happen)?

5. **When** did you first experience your major complaint? _____

6. What have you done **prior** to coming to this office to treat your major and minor complaints? _____

7. When do you **notice** your complaint or complaints the most? AM PM BOTH

8. How long does it last? _____ Minutes _____ Hours

9. What makes it feel **worse**? Sitting Standing Lying Activity Other _____

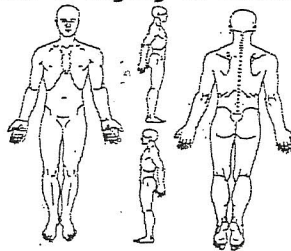
10. What makes it feel **better**? Sitting Standing Lying Activity Drugs Other _____

11. What best describes the character and quality of your major illness or pain?

A: ache B: burning pain T: tingling N: numbness S: sharp K: cramping D: dull pain

12. Have you ever had this problem in the past? Yes No

13. On the diagram below, please **show** where you are experiencing all of your present complaints using the following letters: A: ache B: burning pain T: tingling N: numbness S: sharp K: cramping D: dull pain



14. On the scale below, please **circle** the **severity and intensity** of your **main complaint** (at its' worst):

None	Slight	Mild	Moderate	Severe					
1	2	3	4	5	6	7	8	9	10

15. On the scale below, please **circle** the **percentage of time** you experience your **main complaint**:

Occasional	Intermittent	Frequent	Constant						
10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

16. Does your pain radiate? _____Y _____N Where does it radiate to? _____

Signature _____ Date _____