

NAME: DATE: // Account#:

HISTORY OF ILLNESS / INJURY / PAIN

LOCATION

Chief complaint and its 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:

<input type="checkbox"/> Deadness	<input type="checkbox"/> Prickly	<input type="checkbox"/> Numb	<input type="checkbox"/> Crawling	<input type="checkbox"/> Tingling
<input type="checkbox"/> Stabbing	<input type="checkbox"/> Hurting	<input type="checkbox"/> Pulsating	<input type="checkbox"/> Pins & Needles	<input type="checkbox"/> Pounding
<input type="checkbox"/> Burning	<input type="checkbox"/> Shooting	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Stinging	
<input type="checkbox"/> Dull	<input type="checkbox"/> Sharp	<input type="checkbox"/> Aching	<input type="checkbox"/> Excruciating	

ADDITIONAL ASSOCIATED SIGNS AND SYMPTOMS

If this pain 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 uphill Getting in/out of car

Other:

What relieves this pain/symptom? Resting Sleeping Lifting Exercising Looking up/down Shower Advil
 Stooping Looking side/side Anger 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:

Patient Signature:

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:

___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

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:

___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

Doctor Signature:

Patient Signature:

P = Present • N = Not Present • PN = If it has ever been present in the past

P	N		P	N		P	N		P	N		P	N
		Weakness			Muscle Pain			Seizures			Animal Dander		
		Fatigue			Muscle Weakness			Vertigo			Latex		
		Fever			Muscle Cramps			Dizziness			Food Allergies		
		Chills			Joint Stiffness			Tremors			Penicillin		
		Night Sweats			Joint Tenderness			Loss of Sensation			Pollen		
		Fainting			Spinal Curvature			Loss of Coordination			Second Hand Smoke		
		Nervousness			Back Pain			Weak Grip			Grasses		
		Concentration Loss			Hot Joints			Paralysis			Sulfa Drugs		
		Dizzy Spells			Joint Swelling			Difficulty of Speech			Dairy Products		
		Irritability			Stiff Neck			Tingling			Perfumes		
		Depression			Soreness			Numbness			Hay		
		Memory Loss			Lumps								
		Loss of Sleep			Masses								
		Headache											
		Apprehension											

FOR DOCTOR'S USE ONLY – PLEASE PROCEED TO PAGE 4

Check additional form for additional Review of Systems OPTION FOR ESTABLISHED E & M SERVICES OR SHARED COMMON FILE

____ Previous Review of Systems reviewed. Date of previous Review of Systems was: ____/____/____
 System Reviewed ____ Constitutional ____ Musculoskeletal ____ Neurological ____ Allergic ____ Other,
 please note: _____ No change in
 systems review ____ Previous Past History reviewed and updated. Date of Past History update:
 ____/____/____

____ No change in Past History ____ See old Past History for changes ____ Previous Social History
 reviewed and updated. Date of Social History updated: ____/____/____ ____ No change in Social
 History ____ See old Social History for changes

____ Previous Family History reviewed and updated. Date of Family History updated: ____/____/____
 ____ No change in Family History ____ See old Family History for changes

Doctor
 Signature:
 Patient
 Signature:

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			
	Tranquilizers/Sedatives			
	Birth Control			

Hospitalizations:

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Doctor
Signature:
Patient
Signature:

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 balanced 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

H

obbies:

How did you hear about us?