Reason for Visit Today **Initial Exam ( ) Update ( ) Progress ( ) Final Exam ( )**

Name:_____ **Date:**_____

Main Complaint: _____ **Left /Right/Both**

Definition of Pain: (circle which applies)

Minimal: Pain present but forgotten with activity

Mild: Annoying but does not interfere with activity

Moderate: Pain Requires modification of activity but not disabling

Severe: You are unable to perform normal duties due to pain

Very Severe: Causes you to cry out in Pain

Pain Severity: **Least Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain**

When did it start? **Sudden / Gradual / Cumulative / Chronic / Unsure**

How long has this been going on?_____

Course: **Progressively getting worse / Getting Better / Staying Same**

Past history of this condition? **Yes / No / Unsure**

What treatments have you tried?_____

_____

What happened ? / Injury ? / Unsure ?

_____

Explain anything you feel is important about this condition or injury:_____

_____

When you are in pain, how long does it last? Occasionally / Comes and Goes / Constant /(Min. / Hours / Days / Weeks / Months)
What % of time does it bother you? (please circle: 10, 20, 30, 40, 50, 60, 70, 80, 90, 100)
Does it feel (better) or (worse) in the (Early Morning / Morning / Afternoon Evening / Late Night / Wake you from sleep) ?

Describe how this complaint feels: (circle all that apply) Dull / Sharp / Throbbing / Burning / Deep / Aching / Tingling / Stabbing / Cramping / Numbness / Other _____/ Radiating. If radiating where? Down the (arm / leg / back / etc.)
_____Right side / Left side / Both

What makes it worse? : (circle all that apply) Sitting / Standing / Walking / Bending / Stooping / Lifting / Sleeping /Sneezing / Coughing / Straining / Reaching / Twisting / Looking up / Looking down / Movement / Rest / Lying face up / Driving / Typing / Household Chores / Exercise / going up stairs / going down stairs / Using computer / Lying face down /

What makes it better? (circle all that apply) Sitting / Standing / Walking / Lying face up / Lying face Down / Lying on side ___/ Support Belt or Brace / Knees Bent up / No Movement / Movement / Rest / Heat / Ice /Analgesic topical ointment / Ibuprofen / Tylenol / Medicine_____/ Herbs_____/ Stretching / Exercise / Chiropractic Adjustments

Have you seen another provider for care with this problem? Yes / No / When ?_____X-Rays? Y / N / MRI? Y / N Labs? Y / N

Whom_____Phone#_____Other:_____