Present Complaints

Chief Complaint: _____

_____

Secondary Complaint:_____

_____

Difficulty in:	☐ Standing	☐ Sitting	☐ Bending	☐ Walking	
Pain radiation to the:	☐ Right arm	☐ Left arm	☐ Right leg	☐ Left leg	
Cannot lift:	☐ Light	☐ Moderate	☐ Heavy	☐ Repetitive	
Pain radiating to:	☐ Neck	☐ Base of skull	☐ Ribs	☐ Shoulders	☐ Arms
Pain in the:	☐ Foot	☐ Ankle	☐ Knee	☐ Hip	☐ Heel spurs

What seems to help your problem? _____

Since the time this (these) complaint(s) began, what, if anything, have you tried that **did not** work? _____

Has the problem interrupted your sleep? Yes / No How?_____

Do you feel fully rested after an average night's sleep? Yes / No – Avg hours of sleep:_____

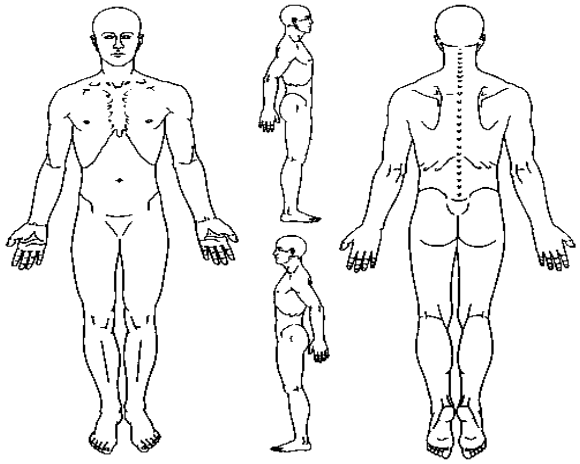
How high would you rate the average stress levels in your life? Low / Medium / High / Very High

List any doctors or therapists that you have seen for this complaint:

1. _____Specialty _____
2. _____Specialty _____
3. _____Specialty _____

Please indicate the location(s) of discomfort below:

(*xxx* – Pain) (*///* - Stabbing)
(*bbb*- Burning) (*www* – Weak)
(*ooo* – Pins) (--- Numb) *S*=Spasms



IMPORTANT: PLEASE CHECK ALL SYMPTOMS

HEAD:
- ☐ Headache
  - ☐ Sinus (allergy)
  - ☐ Entire head
  - ☐ Back of head
  - ☐ Forehead
  - ☐ Temples
  - ☐ Migraine
  - ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headedness
- ☐ Fainting
- ☐ Light bothers eyes
- ☐ Blurred vision
- ☐ Double Vision
- ☐ Loss of vision
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing in ears
- ☐ Bussing in ears

NECK:
- ☐ Pain in neck
- ☐ Neck pain with movement
  - ☐ Forward
  - ☐ Backward
  - ☐ Turn to left
  - ☐ Turn to right
  - ☐ Bend to left
  - ☐ Bend to right
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Popping sounds in neck
- ☐ Arthritis in neck

SHOULDERS:
- ☐ Pain in shoulder joint (R-L)
- ☐ Pain across shoulders
- ☐ Bursitis (R-L)
- ☐ Arthritis (R-L)
- ☐ Can't raise arm
  - ☐ above shoulder level
  - ☐ over head
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder (R-L)
- ☐ Muscle spasms in shoulders

ARMS & HANDS:
- ☐ Pain in upper arm
- ☐ Pain in elbow
- ☐ Movement aggravated
- ☐ Tennis elbow
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Sensation of pins/needles in arms
- ☐ Sensation of pins/needles in fingers
- ☐ Numbness in arms (R-L)
- ☐ Numbness in fingers (R-L)
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Arthritis in fingers
- ☐ Loss of grip strength

MID-BACK:
- ☐ Mid-back pain
- ☐ Location

_____

- ☐ Pain between shoulder blades
- ☐ Sharp stabbing
- ☐ Dull ache
- ☐ Pain from front to back
- ☐ Muscle spasms
- ☐ Pain in kidney area

CHEST:
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs
- ☐ Breast pain
- ☐ Dimpled or orange peel breast
- ☐ Irregular heartbeat

ABDOMEN:
- ☐ Nervous stomach
- ☐ Foods can't eat

_____

- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids

LOW BACK:
- ☐ Low back pain
- ☐ Upper lumbar
- ☐ Lower lumbar
- ☐ Sacroiliac
- ☐ Low back pain is worse when:
  - ☐ Working
  - ☐ Lifting
    - ☐ Stooping
    - ☐ Standing
    - ☐ Sitting
    - ☐ Bending
    - ☐ Coughing
    - ☐ Lying down (sleeping)
    - ☐ Walking
- ☐ Pain is relieved when

_____

- ☐ Slipped disk
- ☐ Low back feels out of place
- ☐ Muscle spasms
- ☐ Arthritis

HIPS, LEGS & FEET:
- ☐ Pain in buttocks (R-L)
- ☐ Pain in hip point (R-L)

☐ Pain down leg (R-L)
☐ Pain down both legs
☐ Knee pain
  ☐ Inside
  ☐ Outside
☐ Leg cramps
☐ Cramps in feet (R-L)
☐ Pins/needles in legs (R-L)
☐ Numbness of leg (R-L)
☐ Numbness of feet (R-L)
☐ Numbness of toes (R-L)
☐ Feet feel cold
☐ Swollen ankles (R-L)
☐ Swollen feet (R-L)

MEN ONLY:
☐ Urinary frequency
☐ Difficulty in starting
☐ Night urination
☐ Prostate pain/swelling

WOMEN ONLY:
☐ Menstrual pain
_____ (where)
☐ Cramping
☐ Irregularity
☐ Cycle
_____ (days)
☐ Birth control
_____ (type)
☐ Hysterectomy
☐ Genital cancer
_____ (type)
☐ Discharge
☐ Menopause
_____(years)
☐ Tumors
☐ Abortions
☐ Are you or do you think you might be pregnant?

GENERAL:
☐ Nervousness
☐ Irritable
☐ Depressed
☐ Fatigue
☐ Generally feel run-down
☐ Normal sleep
_____
☐ Loss of sleep
_____ hrs/night
☐ Loss of weight
_____ lbs.
☐ Gain weight
_____ lbs.
☐ Coffee _____ cups/day
☐ Tea _____ cups/day
☐ Cigarettes
_____ pack/day
☐ Other
_____
☐ Diabetes
☐ Hypoglycemia

MEDICAL HISTORY:
(If any of the following are relevant to your medical history, please check the accompanying box)

☐ Muscle Dystrophy
☐ Rheumatic Fever
☐ Digestive Disorders
☐ Multiple Sclerosis
☐ Sinus Trouble
☐ Convulsions
☐ Backaches
☐ German Measles
☐ Heart Trouble
☐ Dizziness
☐ Diabetes
☐ High Blood Pressure
☐ Venereal Disease
☐ Pins/needles in legs (R-L)
☐ Numbness of leg (R-L)
☐ Numbness of feet (R-L)
☐ Numbness of toes
☐ Feet feel cold
☐ Swollen ankles (R-L)
☐ Nervousness
☐ Swollen feet (R-L)
☐ Cancer
☐ Asthma
☐ Polio
☐ Epilepsy
☐ Numbness
☐ Concussion
☐ Scarlet Fever
☐ Arthritis
☐ Tuberculosis
☐ Hepatitis

History / Lifestyle

List any operations that you've had and approximate dates:

1. _____ Date: _____ Dr: _____
2. _____ Date: _____ Dr: _____
3. _____ Date: _____ Dr: _____
4. _____ Date: _____ Dr: _____

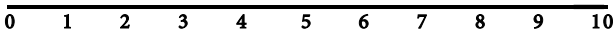
Are you allergic to any medication? Please list: _____

_____

Are you taking any medications? Please list: _____

_____

On a scale of 0-10, 0 being no pain at all and 10 being the worst possible pain imaginable, what would you rate each of your condition?



No Pain/Symptom Worst Possible Pain/Symptom

Are you pregnant? □ Yes / □ No Due date: _____

# of Pregnancies: _____# of Deliveries: _____# of Miscarriages: _____

Do you: Smoke: □ Yes / □ No Amount per day: _____

Drink: □ Yes / □ No □ Light □ Medium □ Heavy

Exercise: □ Never □ Sometimes □ Frequently □ Regularly

Type of exercise: _____ Sports injuries: _____

Spicy Food: □ Never □ Sometimes □ Frequently □ Regularly – Avg # Meals/day: _____

Aversion to: (circle) wind / heat / cold / damp / dryness - Allergies: _____

Fatigue after meals? Yes / No - Gas after meals? Yes / No – Binge Eating? Yes / No

Does anyone in your family have a similar health related problem? □ Yes / □ No

Who?: _____ What condition?: _____

Care they are receiving: _____

Primary Care Physician: _____Phone #:_____

Is there anything else you would like us to know? _____

(continue on back if necessary) _____

_____

_____

Patient Signature: _____ Date: _____