

Name _	e	Date
Chief C	<u>Complaints</u>	
1		for/since
2		for/since
3		for/since
<u>History</u>	ry of Present	
□ <u>Illne</u> (a)	Iness a) When did the illness begin?	
(b)	b) What was the problem at the time?	
(c)	c) What treatment did you receive?	
(d)	d) Give details of the treatment, increase/decrease in sym	ptoms and any further injuries, etc.
□ <u>Injur</u> (a)	<u>ury</u> a)Date of injury?	
	b) How did it happen?	
	c) Where was the pain?	
	d) Where were you treated initially?	
(e)	e) Give all details of the treatment, increase/decrease in sy	ymptoms and any further injuries, etc.



<u>Present Complaints (Fill one section for each body part)</u>

1.	<u>Pain</u>					
(a)	Area of pain?					
(b)	Pain constant/ intermittent?					
(c)	Any pain at night?					
(d)	Severity of pain? On a scale from 1 to 10 (Slight) 1 2 3 4 5 6 7 8 9 10 (Severe)					
(e)	What causes or increase pain?					
(f)	What decreases pain? (Position, rest, medicine, etc.?)					
	Pain Area of pain?					
(b)	Pain constant/ intermittent?					
(c)	Any pain at night?					
(d)	Severity of pain? On a scale from 1 to 10 (Slight) 1 2 3 4 5 6 7 8 9 10 (Severe)					
(e)	What causes or increase pain?					
(f)	What decreases pain? (Position, rest, medicine, etc.?)					
	Pain Area of pain?					
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(c)	Any pain at night?					
(d)	Severity of pain? <i>On a scale from 1 to 10</i> (Slight) 1 2 3 4 5 6 7 8 9 10 (Severe)					
(e)	What causes or increase pain?					
(f)	What decreases pain? (Position rest medicine etc.?)					



Medications:	Name of M	Name of Medications currently taking					
		1					
Past History							
1. List all pro	ovious injurio	c.					
1. <u>List ali pit</u>	evious irijurie	<u>3.</u>					
Type o	of Injury	<u>Year</u>	<u>Treatment</u>	Residual Disability			
							
							
	 						
2. <u>List all pro</u>	evious surger	ies:					
<u>Type o</u>	Type of Surgery		<u>Year</u>	Surgeon's Name			



3.	Any	medica	l ill	ness?

Diabetes	□No	□Yes
Hypertension	□No	□Yes
Cardiac illness	□No	□Yes
Arthritis	□No	□Yes
Other:	□No	□Yes

4.	Any allergies?

Family History

Diabetes	□No	□Yes	Family Member(s) with the illness:
High blood pressure	□No	□Yes	Family Member(s) with the illness:
Bleeding Problems	□No	□Yes	Family Member(s) with the illness:
Cancer	□No	□Yes	Family Member(s) with the illness:
Arthritis	□No	□Yes	Family Member(s) with the illness:
Osteoporosis	□No	□Yes	Family Member(s) with the illness:

Social History

☐ Work in the home ☐ Employed (occupation :) ☐ Student						
□Single □Married □Divorced □Separated □Widowed						
Exercise: Daily Weekly Monthly Rarely Never What type of exercise?						
History of substance abuse? ☐ Yes ☐ No What?						
Smoke currently? ☐ Yes ☐ NoPacks per day foryears.						
Drink Alcohol	? □ Daily □	☐ 1-2 x/weeks	☐ 1-2 x/weeks	s □ 1-2 x/year		



Systems

Are you currently having or have had problems with:

Explain all YES Responses

Eyes	□No	□Yes	Explain:
Ears, Nose, Throat	□No	□Yes	Explain:
Lungs, breathing	□No	□Yes	Explain:
Digestion	□No	□Yes	Explain:
Bowel Moment	□No	□Yes	Explain:
Bladder problem	□No	□Yes	Explain:
Diabetes	□No	□Yes	Explain:
High Blood Pressure	□No	□Yes	Explain:
Bleeding Problems	□No	□Yes	Explain:
Balance Problems	□No	□Yes	Explain:
Numbness/Fainting	□No	□Yes	Explain:
Blackout / Fainting	□No	□Yes	Explain:
Psychological Problems	□No	□Yes	Explain:
Cancer	□No	□yes	Explain:
Arthritis	□No	□Yes	Explain:
Osteoporosis	□No	□Yes	Explain:
Polio	□No	□Yes	Explain:
ТВ	□ No	□Yes	Explain:
Epilepsy	□No	□Yes	Explain:
	•		·
Patient Signature Interpreter Signature			