

PLEASE DESCRIBE YOUR CURRENT MAJOR COMPLAINTS:

Please Rate Your symptoms (1 to 10) with 1 being least serious) ASK RECEPTIONIST FOR AN EXAMPLE

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____

SYMPTOMS ARE WORSE IN MORNING AFTERNOON NIGHT

WHEN AND HOW DID MOST RECENT PROBLEM OCCUR? _____

SYMPTOMS DEVELOPED FROM: JOB RELATED INJURY AUTO ACCIDENT OTHER ACCIDENT

ILLNESS UNKNOWN CAUSE GRADUAL ONSET DATE OCCURRED: _____

SYMPTOMS HAVE PERSISTED FOR # _____ HOUR(S) _____ DAY(S) _____ WEEK(S) _____ MONTH(S) _____ YEAR(S)

SYMPTOMS/COMPLAINTS: COME & GO ARE CONSTANT

HAVE YOU EVER HAD THIS BEFORE: NO YES WHEN? _____

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S): _____

ARE YOU ALLERGIC TO ANY MEDICATIONS NO YES WHAT KIND? _____

ARE YOU TAKING ANY MEDICATIONS NO YES WHAT KIND? _____

NAMES OF MEDICINE _____

ARE YOU PREGNANT NO YES DATE OF LAST MENSTRUAL PERIOD _____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

- BENDING REACHING STRAINING AT STOOL COUGHING SITTING TURNING HEAD
- LIFTING SNEEZING WALKING LYING DOWN STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

- BENDING SITTING LIFTING STANDING LYING DOWN TURNING HEAD REACHING WALKING

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

- blurred vision buzzing in ears cold feet cold hands cold sweats concentration loss /confusion
- constipation depression /weeping spells diarrhea dizziness face flushed fainting fatigue
- fever head seems too heavy headaches insomnia light bothers eyes loss of balance loss of smell loss of taste
- low resistance to colds muscle jerking numbness in fingers numbness in toes pins and needles in arms
- pins and needles in legs ringing in ears shortness of breath stiff neck stomach upset

Patient's Signature: _____ Date: _____