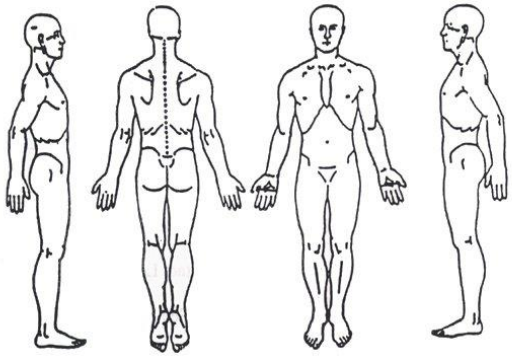
Chief Complaint

Patient Name: _____ Date: _____

Where does it hurt? (Mark an 'X' on the diagram below):



How extreme are your current symptoms? (Circle a number based on the intensity scale listed below):

0-----1------2------3------4------5------6-------7-------8-------9------10

Absent **Uncomfortable** **Agonizing**

Why are you here today? When did these symptoms start?

Are these symptoms as a result of an injury, MVA, or work?

Are these symptoms getting worse, staying the same, or getting better?

How often do you feel the symptoms – constantly, intermittently? Time of day worse – AM or PM?

Does the symptom radiate?

Nature or quality of symptom – sharp, stabbing, aching, throbbing, numbing/tingling?

What aggravates symptoms?

Does this condition interfere with: Work/School, Sleep, Household Activities, Personally/Emotionally

What relieves symptoms, any care attempts already made?

Anything else not discussed yet?

_____

PHYSICIAN SIGNATURE