History of the Chief Complaint

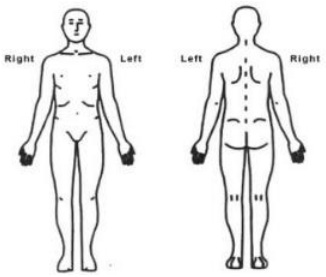
Patient Name (Last, First)	*Date*

Chief Complaint

Please describe your reason for today's visit

What caused your symptoms to first occur?	*When did your symptoms first appear?*

Please mark all regions where you have symptoms occurring:



Question	Yes	No
Have you experienced any traumas/accidents?	□	□
Do your symptoms interfere with daily life/work?	□	□
Have you experienced these symptoms in the past?	□	□
Have you seen other physicians for these symptoms?	□	□
Are you experiencing any tingling/numbness?	□	□
Does your pain radiate to a different region?	□	□
How intense are your symptoms today? ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (least to most intense)		
How intense are your symptoms at their worst? ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (least to most intense)		

How would you describe your symptoms *(Please check all that apply)*?

□ Dull/Achy □ Sore/Tender □ Burning □ Other _____

□ Stiff/Tight □ Sharp/Stabbing □ Tingling/Numb □ Other _____

What, if anything, helps alleviate your symptoms *(Please check all that apply)*?

□ Heat □ Ice □ Stretching/Exercise □ OTC medicine □ Prescription medicine

□ Nothing has worked □ Nothing has been tried □ Chiropractic □ Massage

What, if anything, makes your symptoms worsen?

Do you notice that your symptoms worsen during a specific time of day?

□ First wake up □ Mid-day □ Afternoon □ Evening □ Night-time/during sleep

□ Other

Patient Signature

Patient / Parent / Guardian Signature	*Date of Signature*

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