Patient Name: _____ **Date:** _____
Height: _____
Weight: _____

Complaint

What is your major complaint? _____

Start Date: _____ Possible Cause: _____

Symptoms: _____

Previous doctors seen for complaint: _____

Previous treatment for complaint: _____

Symptom-Aggravating Factors: _____

Symptom-Relieving Factors: _____

Time of Day Symptoms are Best: _____ Time They Are Worst: _____

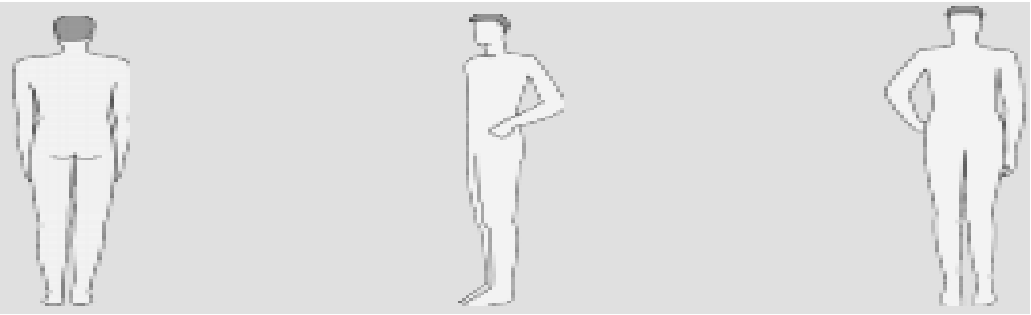
Current Duration of Pain: Intermittent Constant With Certain Motions

Current Level of Pain (0-10) At Rest _____ At Best _____ At Worst _____

Is your pain getting better or worse? _____

Have you had this injury before? YES NO

Mark Areas of Discomfort



Do You Have Any of the Following Today? (Circle All That Apply)

AIDS/HIV
Anemia
Angina
Arteriosclerosis
Arthritis
Asthma
Blood Clots
Bone Infection
Cancer
Cardiac Disease
Chemical Dependency
Circulation Problems
Depression
Diabetes
Epilepsy
Eye Infection
Hemophilia
High/Low Blood Pressure
Joint/Bone Infection
Liver Problems
Lung Issues
Multiple Sclerosis
Musculoskeletal Problems
Parkinsons Disease
Pneumonia
Stroke
STD
Tuberculosis
Urinary Infection

Please Sign and Date to attest that all information above is accurate and correct to the best of your knowledge:

Signature:_____

Date: _____