# History of Chief Complaint

***1.)*** **Please describe in your own words what area of your body is hurting and how and when the problem started:** ______________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

**2.) Please complete the following questionnaire to help describe your condition:**

**Was the Onset of the problem**: ☐Gradual ☐Immediate ☐Cumulative ☐Unknown Cause

**What is the Location of pain**: ☐Right ☐Left ☐Both Sides ☐Midline ☐Switches

**Does the pain Radiate into:** ☐ Arms ☐Legs Please Describe:

**Describe your pain.** ☐Sharp ☐Dull ☐Achy ☐Numb ☐Tingling ☐Stiffness ☐Hot/Burning ☐Other

**Is your pain:** ☐Constant ☐Occasional ☐Random(comes & goes) ☐Other

**Is there any Numbness involved?** ☐No ☐Yes (please explain)

**Do you experience any Muscle Weakness?** ☐No ☐Yes (please explain)

**What time of the day does the pain tend to be the Worse?** ☐AM ☐PM ☐In bed ☐Other(please explain)

**Which of the following factors makes your condition Worse? (please circle all that apply)**
None Sitting Standing Walking Lying on back Lying on stomach Lifting Twisting Pulling
Bending Pushing Sneezing Coughing Working Other:

**Which of the following factors makes your condition Better? (please circle all that apply)**
None Sitting Standing Walking Lying down Squatting Heat Ice Rest Other:

**Are you taking any Medications for you condition?** ☐No ☐Yes
What Type of medications?
Times per day:____________________ For the past _________Days/Weeks

**Are you experiencing Sleep Disturbances?** ☐No ☐Yes…..☐Nightly ☐Occassionally ☐Other

**Have you ever been treated for this condition before?** ☐No ☐Yes **Did treatment help?** ☐No ☐Yes

**Is this condition limiting you from doing your normal Activites of Daily Living?** Please describe.

**Since the onset of this condition is the problem** Better_______% or Worse________%

**What is you normal Work Schedule and is this condition interferring?**

**Please list previous episodes of injury to this area.** (Car accidents, sports injuries, falls etc.)

**3.) *Pain Scale:** At Best = 0 1 2 3 4 5 6 7 8 9 10 At Worst = 0 1 2 3 4 5 6 7 8 9 10
PLEASE RATE YOUR PAIN no pain severe pain no pain severe pain