Chief Complaint

Patient Name ______________________________ Date ______________

Reason for Visit ______________________________

____

When did your symptoms first appear? ______________________________

If you were to guess, what do you think is causing your symptoms? ______________________________

____

On a scale from 1 to 10 (10 being the worst) what would you rate the level of discomfort/pain? ______________

Type of discomfort

☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness

☐ Tingling ☐ Shooting ☐ Stiffness ☐ Cramps

☐ Aching ☐ Burning ☐ Other ______________________________

Is the discomfort/pain

☐ Constant ☐ Varying ☐ Other ______________________________

Is the condition getting worse?

☐ Yes ☐ No

Does it interfere with

☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform are

☐ Sitting ☐ Standing ☐ Walking

☐ Lying down ☐ Bending

Activities or movements that relieve the pain/discomfort

☐ Sitting ☐ Standing ☐ Walking

☐ Lying down ☐ Bending

What treatment have you already received for you condition?

☐ Medications ☐ Surgery ☐ Chiropractic Services ☐ Physical Therapy

☐ None ☐ Other ______________________________

List of Provider(s) Who Have Treated You For This Condition and Date(s) of Last Visit(s)

____

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Hospitalization/Surgical History

Description	**Date**
Falls/Head Injuries ______________________________	______________
Fractures/Broken Bones ______________________________	______________
Surgeries ______________________________	______________
Hospitalization ______________________________	______________
Orthopedic Replacements ______________________________	______________