CURRENT COMPLAINT HISTORY FOR PATIENT

Patient Name: _____ **Date:** _____

Please check all boxes that apply to your condition **and fill in the spaces that describe your present complaint(s). Also, the information you provide concerning past symptoms will help in assisting the doctor to better understand your present complaints and total health picture.**

Please list your present complaint(s) and mark your level of pain today for each complaint – If you have more than one area of complaint, list them in order of most severe to least severe.

1. _____ **Duration – (How Long / Date):** _____ **# of Previous Episodes:** _____
   (*Please circle one.*) **(No pain)** 0 1 2 3 4 5 6 7 8 9 10 **(Worst pain imaginable)**
2. _____ **Duration – (How Long / Date):** _____ **# of Previous Episodes:** _____
   (*Please circle one.*) **(No pain)** 0 1 2 3 4 5 6 7 8 9 10 **(Worst pain imaginable)**
3. _____ **Duration – (How Long / Date):** _____ **# of Previous Episodes:** _____
   (*Please circle one.*) **(No pain)** 0 1 2 3 4 5 6 7 8 9 10 **(Worst pain imaginable)**

Has anyone treated you for this episode? ❑Yes ❑No If yes, by whom? _____

How did your **symptoms begin?**

❑Immediately after a specific incident ❑After multiple Incidents ❑Gradually developed over time ❑Other _____

What makes your **symptoms better?**

❑Nothing ❑Lying down ❑Standing ❑Sitting ❑Movement/Exercise ❑Other _____

What makes your **symptoms worse?**

❑Nothing ❑Lying down ❑Standing ❑Sitting ❑Movement/Exercise ❑Other _____

Are your **symptoms?**

❑Decreasing ❑Increasing
❑Not Changing ❑Other _____

Description of pain or symptoms:

❑Sharp ❑Shooting
❑Dull ❑Burning
❑Ache ❑Numb
❑Weakness ❑Tingling
❑Throbbing ❑Other_____

Does your pain **move** or **radiate?**

❑Yes ❑No Where _____

Check the best and worse **times of the day** for your **pain**:

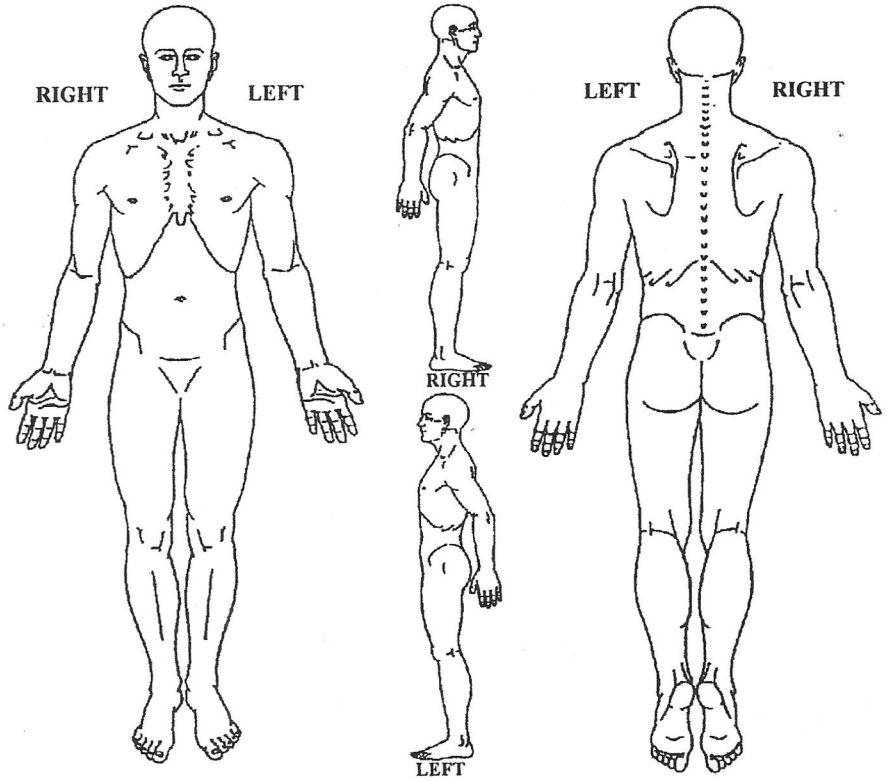
Worse	**Best**
❑First Awake	❑First Awake
❑Morning	❑Morning
❑Afternoon	❑Afternoon
❑Evening	❑Evening
❑Nighttime	❑Nighttime
❑Other	❑Other

Frequency of pain or symptoms:

❑Constant (76 – 100%)
❑Frequent (51 – 75%)
❑Occasional (26 – 50%)
❑Intermittent (25% or less)

SHOW US YOUR PAIN
USE THE LETTERS BELOW TO INDICATE THE TYPE
AND LOCATION OF YOUR SYMPTOMS TODAY

KEY: **A** = ACHE **B** = BURNING **N** = NUMBNESS **P** = PINS & NEEDLES
S = STABBING **X** = STIFFNESS **T** = THROBBING **O** = OTHER



How many days out of **an average week** are you in **pain?** (Please circle one.) 1 2 3 4 5 6 7

How much time during the **day** are you in **pain?**

❑less than 1 hour ❑1 to 6 hours ❑6 to 12 hours ❑12 to 18 hours ❑18 to 24 hours ❑24 hours

Patient's/Guardian's Signature: _____ **Date:** _____