PATIENT HISTORY

Patient Name: _____DOB: _____Date:_____

1. What is your main complaint? _____
2. On the scale below, please circle the severity of your main complaint (At It's worst)

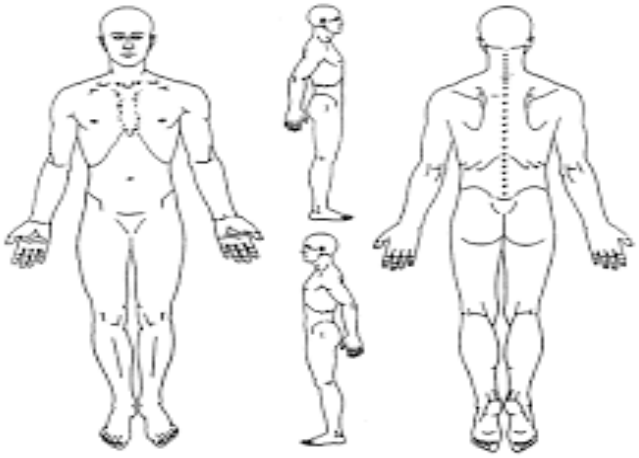
NONE		SLIGHT		MILD		MODERATE			SEVERE
1	2	3	4	5	6	7	8	9	10

3. On the scale below please circle the percentage of time you experience your main complaint:

OCCASIONAL				INTERMITTENT			FREQUENT		CONSTANT
0%	10%	20%	30%	40%	50%	60%	70%	80%	90-100 %

4. How long have you been experiencing your main complaint? _____
5. On the diagram below, please show where you are experiencing all of your present complaints using the following letters:

A: ache B: Burning pain C: Cramping D: Dull pain R: Throbbing pain N: Numbness T: Tingling



6. When do you notice it most? AM PM (please circle one)
   How long does it last? _____mins _____hrs
7. What makes It feel better?_____
8. What makes it feel worse?_____
9. Have you ever had this problem in the past? Yes No
10. Have you seen another provider for this problem? Yes No
11. Have you lost time from work because of it? Yes No
    Dates? _____ to _____
12. Since your last visit have you experienced:
    1. Any change in your history? Yes or No
    2. Any change in medication? Yes or No

Do you have pain and /or difficulty performing any of the following activities?

Personal care _____
Lifting _____
Reading _____
Concentrating _____
Work _____
Driving _____
Sleeping _____
Recreation _____
Walking _____
Sitting _____
Standing _____
Social life _____

To The Best of My Knowledge, The questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my Responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____
Signature of the Patient, Parent or Guardian **Date**

_____ _____
Signature of Examiner / Clinician **Date**