DOB

BP Pulse

# PATIENT HISTORY/CONSULTATION

**Patient Name:** _____

**PAIN SCALE:** 0 1 2 3 4 5 6 7 8 9 10

*(1=@o pain; 1-5=mild to moderate: 6-10=moderate to severe)*

**MUSCULOSKELETAL / CHRONIC PAIN COMPLAINT'(S'):**

1._____ 2._____

**Onset of Complaint(s): When did it start? i.e. Approximate Date(s)?** _____

**The problem began:** Suddenly Gradually Insidiously

**How do you think your problem began?**_____

_____

**How often do you experience your symptoms?**

Constantly (76-100% of the time) Occasionally (26-50% of the time) Daily
Frequently (51-75% of the time) Intermittently (1-25% of the time) Weekly

**How would you describe the type of pain?**

Stabbing w/ motion Stabbing Throbbing Dull Radiating
Electric like w/ motion Electric like Pinching Achy Burning
Shooting w/ motion Shooting Tightness Stiff Numb
Sharp w/ motion Sharp Tearing Pressure-like Tingly

**How are your symptoms changing with time?**

Getting Better Getting Worse Staying the Same

**What aggravates your complaint(s)?**

Prolonged Standing Lifting Exercises Writing/Typing Sleeping/Lying down
Prolonged Sitting Driving Running Household/Yard Chores Hot/Cold Weather
Sitting to Standing up Bending Walking Bright Light (photophobia)
Cough, Sneeze, Strain Using Stairs Loud Noise (phonophobia)

**What makes it better?----------**

**How much has the problem interfered with your work / home life? Occupation?**

Not at all A little bit Moderately Quite a bit Extremely

**How much has the problem interfered with your social activities?**

Not at all A little bit Moderately Quite a bit Extremely

**Who else have you seen for your problem?**

Primary Care Neurologist Massage Therapist Acupuncturist ER/Hospital/Urgent care
Pain Specialist Chiropractor Naturopathic Podiatrist
Orthopedic Physical Therapist Homeopathic Dentist

**Prior Treatments Attempted?**

Medications (RX) Physical Therapy Chiropractic Acupuncture
Medications (OTC) Massage Therapy Surgery Home Remedy

**RX medications, OTC medications, vitamins, or supplements you are currently taking WITH DOSING if known:**

_____

_____

Anything else pertinent to your visit today?

_____

Doctor Signature_____ Date:_____

Diagnosis: 1 _____ Diagnosis 2_____