PATIENT'S PRESENT COMPLAINT

Name_____ Date _____

Address_____ City _____ State _____ Zip _____

Telephone (H)_____ (C) _____ (W) _____ (Email) _____

Soc. Sec. #_____ Driver's Lic. # _____ State issued _____

Birthdate _____ /_____/_____ Age _____ Sex ◯M ◯F Satus ◯M ◯S ◯W ◯D

Occupation _____ Employer _____

Address _____ City _____ State _____

Spouse's Name _____ Occupation _____ Employer _____

Person Responsible for this Account _____ Health Plan _____

Subscriber's Name _____ ID# _____ Group # _____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. DESCRIBE YOUR PRESENT COMPLAINT.
This information is necessary to assist your health care provider understand your health condition.

Please describe your problem and how it began. Date Problem began: ____/____/____

How bad is your pain? (Circle a number) ◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10
No Pain Unbearable Pain

How often are your symptoms present? ☐Constantly ☐Frequently ☐Occasionally ☐Intermittently

Describe your current pain/symptoms:

☐Sharp/Stabbing	☐Throbbing	☐Aches
☐Dull	☐Soreness	☐Weakness
☐Numbness	☐Shooting	☐Gripping
☐Burning	☐Tingling	☐Other _____

Since it began, is your problem: ☐Improving ☐Getting Worse ☐No Change

What makes the problem better?

☐Nothing	☐Lying Down	☐Walking
☐Standing	☐Sitting	☐Movement
☐Exercise	☐Inactivity/rest	☐Other _____

What makes the problem worse?

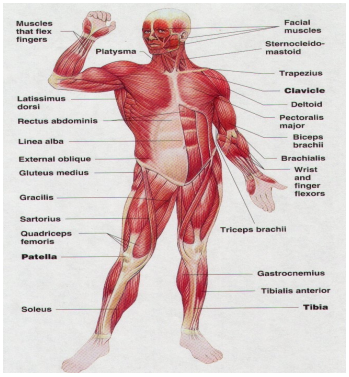
☐Nothing	☐Lying Down	☐Walking
☐Standing	☐Sitting	☐Movement
☐Exercise	☐Inactivity/rest	☐Other _____

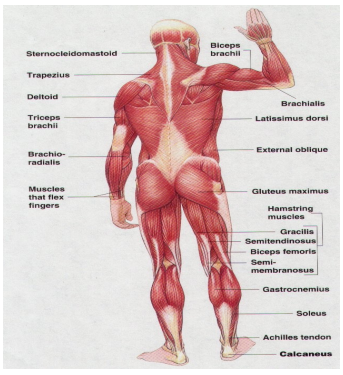
Can you perform your daily home activities?	☐Yes	☐Yes, only with help	☐Not at all
Do you exercise?	☐Yes, almost daily	☐Yes, occasionally	☐Not at all
Describe your job requirements:	☐Mainly sitting	☐Light Labor	☐Heavy Labor
Can you perform your daily work activities?	☐Yes, all activities	☐Only some	☐Not at all
Describe your stress level:	☐None to mild	☐Moderate	☐High

What treatment have you had for this condition in the past? (surgery, medications, injections, therapy, chiropractic)

Have you had X-rays, MRI, or other tests for this condition? What tests and When?

Mark an X on the picture where you have pain or other symptoms, include symptoms of pain, numbness, or tingling





Patient Signature _____ Date _____

PATIENT HEALTH QUESTIONNAIRE

Patient Name_____ Date _____

If you have *ever* had a listed symptom in the past, please check that symptom in the Past Column.
If you are presently troubled by a particular symptom, check that symptom in the Present column.
KNOWLEDGE OF THESES CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.

Past	Present	
☑	☐	Neck Pain
☐	☐	Shoulder Pain (R___ L___)
☐	☐	Pain in Upper Arm or Elbow (R___ L___)
☐	☐	Hand Pain (R___ L___)
☐	☐	Wrist Pain (R___ L___)
☐	☐	Upper Back Pain
☐	☐	Low Back Pain
☐	☐	Pain in Upper Leg or Hip (R___ L___)
☐	☐	Pain in Lower Leg or Knee (R___ L___)
☐	☐	Jaw Pain
☐	☐	Swelling, Stiffness of Joint's)
☐	☐	Fainting
☐	☐	Visual Disturbances
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Headaches
☐	☐	Muscular In coordination
☐	☐	Tinnitus (Ear Noises)
☐	☐	Rapid Heart Beat
☐	☐	Chest Pain
☐	☐	Loss of Appetite
☐	☐	Anorexia
☐	☐	Abnormal Weight
		☐ Gain ☐ Loss
☐	☐	Excessive Thirst
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	General Fatigue
☐	☐	Irregular Menstrual Flow
☐	☐	Profuse Menstrual Flow
☐	☐	Breast
☐	☐	Endometriosis
☐	☐	PMS
☐	☐	Loss of Bladder Control
☐	☐	Painful Urination
☐	☐	Frequent Urination
☐	☐	Abdominal Pain
☐	☐	Constipation/irregular bowel habits
☐	☐	Difficulty in Swallowing
☐	☐	Heartburn/Indigestion
☐	☐	Dermatitis/Eczema/Rash

Past	Present	
☐	☐	Depression
☐	☐	Aortic Aneurysm
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Heart Attack (date _____)
☐	☐	Stroke (date _____)
☐	☐	Asthma
☐	☐	Cancer, Explain _____
☐	☐	Tumor, Explain _____
☐	☐	Prostate Problems
☐	☐	Blood Disorder
☐	☐	Emphysema (chronic lung disorder)
☐	☐	Arthritis
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Ulcer
☐	☐	Liver/Gallbladder problems
☐	☐	Kidney Stones
☐	☐	Hepatitis
☐	☐	Bladder Infection
☐	☐	Kidney Disorders (by condition)
☐	☐	Colitis
☐	☐	Irritable Colon
☐	☐	HIV/AIDS
☐	☐	Other erefredsf

If a family member has had any of the following, please mark the appropriate box:

☐ Cancer	☐ Epilepsy
☐ Rheumatoid Arthritis	☐ Chronic Back Problems
☐ Diabetes	☐ Chronic Headaches
☐ Heart Problems	☐ Lupus
☐ Lung Problems	☐ Other
☐ High Blood Pressure _____	

Yes	No	
☐	☐	Do you have a permanent disability rating?
		Location _____
		Date rating received _____
		Rating Percentage _____%

Present Weight _____pounds
Height _____feet _____inches

Please check any of the following that apply to you

Past	Present	
☐	☐	Pregnancy, # of births _____
☐	☐	Birth Control Pills, type
☐	☐	Medications (list if not listed elsewhere)
☐	☐	Hospitalizations/Surgical Procedures (list if not described elsewhere)_____

Past	Present	
☐	☐	Tobacco
☐	☐	Alcohol
☐	☐	Drug or Alcohol Dependence
☐	☐	Coffee/Tea/Caffeinated Soft Drinks: cups/cans per day_____

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health or health plan coverage in the future.

Patient's Signature_____ Date_____