

CURRENT COMPLAINT HISTORY (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:

- | | |
|--------------------------------------|--------------------------------------|
| <u>Worse</u> | <u>Best</u> |
| <input type="checkbox"/> First Awake | <input type="checkbox"/> First Awake |
| <input type="checkbox"/> Morning | <input type="checkbox"/> Morning |
| <input type="checkbox"/> Afternoon | <input type="checkbox"/> Afternoon |
| <input type="checkbox"/> Evening | <input type="checkbox"/> Evening |
| <input type="checkbox"/> Nighttime | <input type="checkbox"/> Nighttime |
| <input type="checkbox"/> Other | <input type="checkbox"/> 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

The diagrams show a front view of a human torso and legs, a side view, and a back view. The front view is labeled 'RIGHT' on the left side and 'LEFT' on the right side. The back view is labeled 'LEFT' on the left side and 'RIGHT' on the right side. The side view is labeled 'RIGHT' at the bottom. The diagrams are intended for marking symptoms with letters A through O.

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: _____