

Current Problem Information

Name: _____ Date: ____/____/____

Name of current problem _____ i.e. left hand pain, right ankle injury etc.

When did your problem begin? Date: ____/____/____, or _____ days, weeks, months, years ago

Is this a work related injury? Yes No (please circle one)

Is this an automobile accident? Yes No (please circle one)

Please describe the symptoms or injury:

Description of symptoms: (Please circle and fill in blanks)

Location: (Left / Right) Body Area: _____ pain radiates to:

Pain quality: Sharp, dull, throbbing, stabbing, stinging, burning, other _____

Severity on a scale of 1-10: 0 1 2 3 4 5 6 7 8 9 10

Duration: Constant, Intermittent, length of time symptoms last _____, time between symptoms _____ minutes _____, hours _____, days _____, weeks _____, months _____

Timing: Exercise, nightly, mornings, evenings, other _____

Trends: Improving, worsening, stable and not changing, recurrent, other _____

Modifying factors: What makes it better? _____
what makes it worse? _____

Better positions: Sitting, standing, walking, lying on back, lying on side L/R, position doesn't matter

Worse positions: Sitting, standing, walking, lying on back, lying on side L/R, position doesn't matter

Associated symptoms: Bruising, numbness, tingling, locking, swelling, other _____

Previous treatment for problem: Dr. _____, ER/Clinic _____, Other _____, Date _____

Diagnostic studies for this problem/facility where study was done: MRI/_____, x-rays/_____,
CT scan/_____, NCV/EMG/_____, Other? _____

Signature of Patient or Legal Guardian: _____ Date: ____/____/____

Review of systems: Please circle all that apply:

General: Chills, fatigue, fever, other _____, unexpected weight loss, weight gain, none

Neurological: Dizziness, numbness, other _____, tingling, or tremor, unsteady gait, none

Gastrointestinal: Abdominal pain, black stools, bloody stools, heartburn, other _____, none

Cardiovascular: Chest pain, fainting, heart murmur, other _____, palpitations, none

Respiratory: Chest tightness, cough, other _____, pain breathing, shortness of breath, snoring, wheezing, none

Genitourinary: Blood in urine, flank pain, frequency, other _____, urgency, painful urination, none

Dermatologic: Abrasions, grayish skin, itching, other _____, poor healing, skin redness, skin changes, lacerations, none

Musculoskeletal: Feeling of heat, joint pain, joint stiffness, joint swelling, joint instability, other _____, none

Endocrine: Abnormal blood glucose, cold intolerance, excessive thirst, frequency of urination, heat intolerance, other _____, none

Hematologic: Bleeding tendency, bruising easily, other _____, none

Mental status: Anxiety, depression, hallucinations, nervousness, other _____, none

Ophthalmologic: Blurred vision, corrective lenses, eye pain, other _____, redness, watering eyes, none

ENT: Difficulty swallowing, earache, headache, nosebleeds, other _____, ringing in ears, none

OB/GYN: Menopause, painful periods, pregnant, other _____, none/not applicable

Signature of Patient or Guardian: _____ Date: ____/____/____