# Current Complaint History

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 make your symptoms worse?
□ Nothing □ Lying down □ Standing □ Sitting □ Movement/Exercise □ Other:_____

Are your symptoms:
□ Decreasing □ Increasing
□ Not changing □ Other:_____

Description of pain / symptoms:
□ Sharp □ Shooting
□ Dull □ Burning
□ Ache □ Numb
□ Weakness □ Tingling
□ Throbbing □ Other:_____

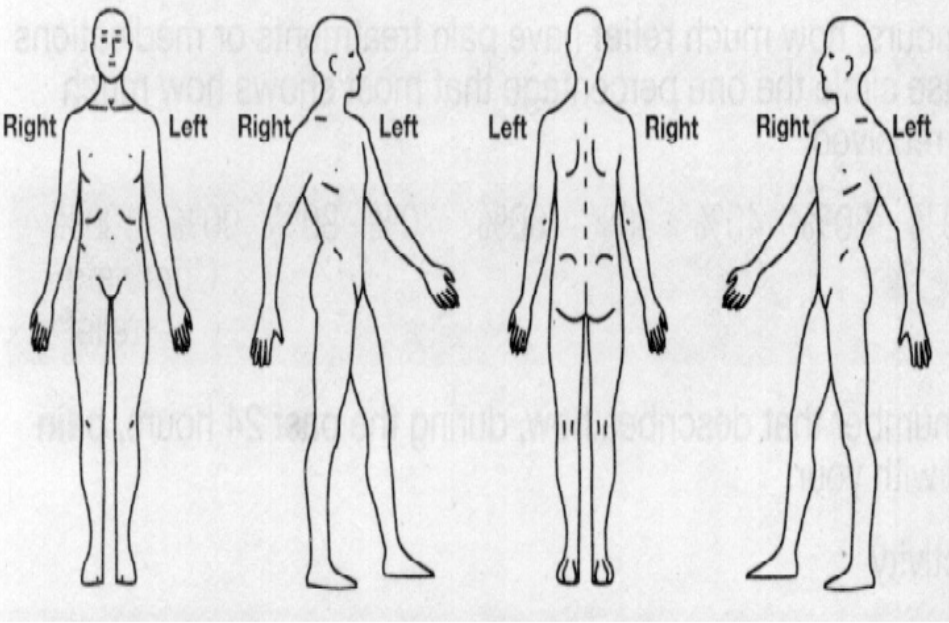
Does your pain move or radiate?
□ Yes/Where:_____ □ No

Check the best and worst times of the day for your pain:

| Worst: | Best: |
|---|---|
| □ First Awake | □ First Awake |
| □ Morning | □ Morning |
| □ Afternoon | □ Afternoon |
| □ Evening | □ Evening |
| □ Nighttime | □ Nighttime |
| □ Other | □ Other |

_____

Frequency of pain / symptoms:
□ Constant (76 – 100%)
□ Frequent (51 – 75%)
□ Occasional (26 – 50%)
□ Intermittent (25% or less)




Use the letters below to indicate the type and location of your symptoms today

Key: A-Aching B-Burning N-Numbness P-Pins and Needles
S- Stabbing X-Stiffness T-Throbbing O-Other

How many days out of an average week are you in pain: 1 2 3 4 5 6 7 (Please circle one)

How much time during the day are you in pain:
□ Less than 1 hour □ 1-6 hours □ 6-12 hours □ 12-18 hours □ 18-23 hours □ 24 hours

Signature:_____ Date:_____