# History of Chief Complaint

Patient Name: _____ Date: _____

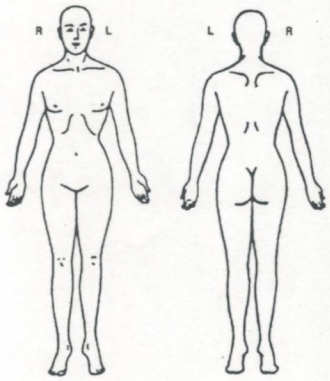
1. Chief Complaint:

   a. Neck Pain b. Mid Back Pain
   c. Low Back Pain d. Arm Pain L/R
   e. Leg Pain L/R f. Headache
   g. Other: _____

2. Mode of Onset
   a. Overexertion/Strenuous Position
   b. Auto Accident
   c. Fall/ Trip/ Slip
   d. Other: _____

3. Date of Onset: _____

4. Location: (Please Circle)




5. Severity:
   a. Mild-Annoyance – no Impairment
   b. Slight – Some mild Impairment
   c. Moderate – marked impairment
   d. Severe – incapacitated/ bed ridden

6. Pain Scale (please circle one)

   0 1 2 3 4 5 6 7 8 9 10

   No Pain Bed Ridden

7. Duration:
   a. Intermittent ( 25 % of the time)
   b. Occasional ( 25%-50% of the time)
   c. Frequent ( 50% - 75% of the time)
   d. Constant ( 76% - 100% of the time)
   e. Other: _____

8. Character:
   a. Dull ache
   b. Sharp Stabbing
   c. Throbbing
   d. Burning
   e. Other: _____

9. Relation to Other Body Systems:
   Bowel/Bladder
   Muscle Weakness
   Numbness/ Tingling
   No Apparent Relationship
   Other: _____

10. Relieving Factors:
   a. Rest/ Exercise
   b. Sitting/standing/lying
   c. Bracing/Taping
   d. Hot/Cold Packs
   e. Other: _____

11. Aggravating Factors:
   a. Cough/Sneeze/Bowl Movements
   b. Lifting/Bending/Push/Pull
   c. Driving/Riding/Sitting
   d. Walking/Standing/Running
   e. Changing Body positions
   f. Other: _____

12. Medications Taken:
   a. Asprin
   b. Ibuprofen
   c. Acctominophen
   d. Naxproxen Sodium
   e. Other: _____