

NAME: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ Account#: \_\_\_\_\_

**HISTORY OF ILLNESS / INJURY / PAIN**

**LOCATION**

Chief complaint and its location: \_\_\_\_\_

What caused the onset? \_\_\_\_\_

Date of onset? \_\_\_\_/\_\_\_\_/\_\_\_\_

**TIMING AND DURATION**

How often do you experience this pain? \_\_\_\_\_ Constant \_\_\_\_\_ Frequent \_\_\_\_\_ Intermittent \_\_\_\_\_ Occasional

**SEVERITY**

On a scale of 0 to 10 with 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain.

0 = None	1 = Minimal	2 = Very Mild	3 = Moderate	4 = Mild to Moderate	5 = Moderate
6 = Moderate to Severe	7 = Mildly Severe, Restricts Some Activity	8 = Severe, Limits Most Activity	9 = Very Severe	10 = Excruciating	

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

\_\_\_\_0 \_\_\_\_1 \_\_\_\_2 \_\_\_\_3 \_\_\_\_4 \_\_\_\_5 \_\_\_\_6 \_\_\_\_7 \_\_\_\_8 \_\_\_\_9 \_\_\_\_10

What is the least intense the symptom has been on a scale of 0 to 10?

\_\_\_\_0 \_\_\_\_1 \_\_\_\_2 \_\_\_\_3 \_\_\_\_4 \_\_\_\_5 \_\_\_\_6 \_\_\_\_7 \_\_\_\_8 \_\_\_\_9 \_\_\_\_10

What is the most intense the symptom has been on a scale of 0 to 10?

\_\_\_\_0 \_\_\_\_1 \_\_\_\_2 \_\_\_\_3 \_\_\_\_4 \_\_\_\_5 \_\_\_\_6 \_\_\_\_7 \_\_\_\_8 \_\_\_\_9 \_\_\_\_10

**ASSOCIATED SIGNS AND SYMPTOMS**

How does this symptom affect your movement? \_\_\_\_\_ Inflexibility \_\_\_\_\_ Stiffness \_\_\_\_\_ Spasms \_\_\_\_\_ Cramps

Other: \_\_\_\_\_

**QUALITY**

How would you best describe the sensation of the pain/symptom:

- |               |               |                |                     |               |
|---------------|---------------|----------------|---------------------|---------------|
| ____ Deadness | ____ Prickly  | ____ Numb      | ____ Crawling       | ____ Tingling |
| ____ Stabbing | ____ Hurting  | ____ Pulsating | ____ Pins & Needles | ____ Pounding |
| ____ Burning  | ____ Shooting | ____ Throbbing | ____ Stinging       |               |
| ____ Dull     | ____ Sharp    | ____ Aching    | ____ Excruciating   |               |

**ADDITIONAL ASSOCIATED SIGNS AND SYMPTOMS**

If this pain radiates or travels, please identify where to: \_\_\_\_\_

**MODIFYING FACTORS**

What aggravates the pain/symptom?

- |                         |                      |                      |                        |                            |
|-------------------------|----------------------|----------------------|------------------------|----------------------------|
| ____ Flashing lights    | ____ Sneezing        | ____ Lifting         | ____ Exercising        | ____ Looking up/down       |
| ____ Coughing           | ____ Sitting         | ____ Stooping        | ____ Looking side/side | ____ Anger                 |
| ____ Standing           | ____ Depression      | ____ Stress          | ____ Driving           | ____ Walking               |
| ____ Getting out of bed | ____ Pushing         | ____ Emotional upset | ____ Pulling           | ____ Repetitive movement   |
| ____ Carrying           | ____ Straining at BM | ____ Climbing stairs | ____ Walking uphill    | ____ Getting in/out of car |

Other: \_\_\_\_\_

What relieves this pain/symptom?

- |                  |                   |               |                        |                      |
|------------------|-------------------|---------------|------------------------|----------------------|
| ____ Resting     | ____ Sleeping     | ____ Lifting  | ____ Exercising        | ____ Looking up/down |
| ____ Shower      | ____ Advil        | ____ Stooping | ____ Looking side/side | ____ Anger           |
| ____ Mineral Ice | ____ Other: _____ |               |                        |                      |

Over the past weeks/months this complaint is: \_\_\_\_\_ Improving \_\_\_\_\_ Getting worse \_\_\_\_\_ About the same

Patient history was obtained from: \_\_\_\_\_ Patient \_\_\_\_\_ Father \_\_\_\_\_ Mother \_\_\_\_\_ Son \_\_\_\_\_ Daughter

Have you seen anyone for this condition? \_\_\_\_\_ YES \_\_\_\_\_ NO WHOM? \_\_\_\_\_

Do you have a pacemaker? _____ YES _____ NO	Are you Pregnant? _____ YES _____ NO
	Do you think you may be pregnant? _____ YES _____ NO

Doctor Signature: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

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**SECONDARY COMPLAINT & LOCATION**

Location \_\_\_\_\_ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?  
\_\_\_\_0 \_\_\_\_1 \_\_\_\_2 \_\_\_\_3 \_\_\_\_4 \_\_\_\_5 \_\_\_\_6 \_\_\_\_7 \_\_\_\_8 \_\_\_\_9 \_\_\_\_10

What is the least intense the symptom has been on a scale of 0 to 10?  
\_\_\_\_0 \_\_\_\_1 \_\_\_\_2 \_\_\_\_3 \_\_\_\_4 \_\_\_\_5 \_\_\_\_6 \_\_\_\_7 \_\_\_\_8 \_\_\_\_9 \_\_\_\_10

What is the most intense the symptom has been on a scale of 0 to 10?  
\_\_\_\_0 \_\_\_\_1 \_\_\_\_2 \_\_\_\_3 \_\_\_\_4 \_\_\_\_5 \_\_\_\_6 \_\_\_\_7 \_\_\_\_8 \_\_\_\_9 \_\_\_\_10

**ASSOCIATED SIGNS AND SYMPTOMS**

How does this symptom affect your movement? \_\_\_\_\_Inflexibility \_\_\_\_\_Stiffness \_\_\_\_\_Spasms \_\_\_\_\_Cramps

Other: \_\_\_\_\_

How would you best describe the sensation of the pain/symptom:

- |              |              |               |                    |              |
|--------------|--------------|---------------|--------------------|--------------|
| ____Deadness | ____Prickly  | ____Numb      | ____Crawling       | ____Tingling |
| ____Stabbing | ____Hurting  | ____Pulsating | ____Pins & Needles | ____Pounding |
| ____Burning  | ____Shooting | ____Throbbing | ____Stinging       |              |
| ____Dull     | ____Sharp    | ____Aching    | ____Excruciating   |              |

Over the past weeks/months this complaint is: \_\_\_\_\_Improving \_\_\_\_\_Getting worse \_\_\_\_\_About the same

**THIRD COMPLAINT & LOCATION**

Location \_\_\_\_\_ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?  
\_\_\_\_0 \_\_\_\_1 \_\_\_\_2 \_\_\_\_3 \_\_\_\_4 \_\_\_\_5 \_\_\_\_6 \_\_\_\_7 \_\_\_\_8 \_\_\_\_9 \_\_\_\_10

What is the least intense the symptom has been on a scale of 0 to 10?  
\_\_\_\_0 \_\_\_\_1 \_\_\_\_2 \_\_\_\_3 \_\_\_\_4 \_\_\_\_5 \_\_\_\_6 \_\_\_\_7 \_\_\_\_8 \_\_\_\_9 \_\_\_\_10

What is the most intense the symptom has been on a scale of 0 to 10?  
\_\_\_\_0 \_\_\_\_1 \_\_\_\_2 \_\_\_\_3 \_\_\_\_4 \_\_\_\_5 \_\_\_\_6 \_\_\_\_7 \_\_\_\_8 \_\_\_\_9 \_\_\_\_10

**ASSOCIATED SIGNS AND SYMPTOMS**

How does this symptom affect your movement? \_\_\_\_\_Inflexibility \_\_\_\_\_Stiffness \_\_\_\_\_Spasms \_\_\_\_\_Cramps

Other: \_\_\_\_\_

How would you best describe the sensation of the pain/symptom:

- |              |              |               |                    |              |
|--------------|--------------|---------------|--------------------|--------------|
| ____Deadness | ____Prickly  | ____Numb      | ____Crawling       | ____Tingling |
| ____Stabbing | ____Hurting  | ____Pulsating | ____Pins & Needles | ____Pounding |
| ____Burning  | ____Shooting | ____Throbbing | ____Stinging       |              |
| ____Dull     | ____Sharp    | ____Aching    | ____Excruciating   |              |

Over the past weeks/months this complaint is: \_\_\_\_\_Improving \_\_\_\_\_Getting worse \_\_\_\_\_About the same

**FOURTH COMPLAINT & LOCATION**

Location \_\_\_\_\_ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?  
\_\_\_\_0 \_\_\_\_1 \_\_\_\_2 \_\_\_\_3 \_\_\_\_4 \_\_\_\_5 \_\_\_\_6 \_\_\_\_7 \_\_\_\_8 \_\_\_\_9 \_\_\_\_10

What is the least intense the symptom has been on a scale of 0 to 10?  
\_\_\_\_0 \_\_\_\_1 \_\_\_\_2 \_\_\_\_3 \_\_\_\_4 \_\_\_\_5 \_\_\_\_6 \_\_\_\_7 \_\_\_\_8 \_\_\_\_9 \_\_\_\_10

What is the most intense the symptom has been on a scale of 0 to 10?  
\_\_\_\_0 \_\_\_\_1 \_\_\_\_2 \_\_\_\_3 \_\_\_\_4 \_\_\_\_5 \_\_\_\_6 \_\_\_\_7 \_\_\_\_8 \_\_\_\_9 \_\_\_\_10

**ASSOCIATED SIGNS AND SYMPTOMS**

How does this symptom affect your movement? \_\_\_\_\_Inflexibility \_\_\_\_\_Stiffness \_\_\_\_\_Spasms \_\_\_\_\_Cramps

Other: \_\_\_\_\_

How would you best describe the sensation of the pain/symptom:

- |              |              |               |                    |              |
|--------------|--------------|---------------|--------------------|--------------|
| ____Deadness | ____Prickly  | ____Numb      | ____Crawling       | ____Tingling |
| ____Stabbing | ____Hurting  | ____Pulsating | ____Pins & Needles | ____Pounding |
| ____Burning  | ____Shooting | ____Throbbing | ____Stinging       |              |
| ____Dull     | ____Sharp    | ____Aching    | ____Excruciating   |              |

Over the past weeks/months this complaint is: \_\_\_\_\_Improving \_\_\_\_\_Getting worse \_\_\_\_\_About the same

Doctor Signature: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

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P = Present • N = Not Present • PN = If it has ever been present in the past

P	N		PN	P	N		PN	P	N		PN	P	N		PN
		Weakness				Muscle Pain				Seizures				Animal Dander	
		Fatigue				Muscle Weakness				Vertigo				Latex	
		Fever				Muscle Cramps				Dizziness				Food Allergies	
		Chills				Joint Stiffness				Tremors				Penicillin	
		Night Sweats				Joint Tenderness				Loss of Sensation				Pollen	
		Fainting				Spinal Curvature				Loss of Coordination				Second Hand Smoke	
		Nervousness				Back Pain				Weak Grip				Grasses	
		Concentration Loss				Hot Joints				Paralysis				Sulfa Drugs	
		Dizzy Spells				Joint Swelling				Difficulty of Speech				Dairy Products	
		Irritability				Stiff Neck				Tingling				Perfumes	
		Depression				Soreness				Numbness				Hay	
		Memory Loss				Lumps									
		Loss of Sleep				Masses									
		Headache													
		Apprehension													

**FOR DOCTOR'S USE ONLY – PLEASE PROCEED TO PAGE 4**

Check additional form for additional Review of Systems  
OPTION FOR ESTABLISHED E & M SERVICES OR SHARED COMMON FILE

\_\_\_\_ Previous Review of Systems reviewed. Date of previous Review of Systems was: \_\_\_\_/\_\_\_\_/\_\_\_\_

System Reviewed

\_\_\_\_ Constitutional \_\_\_\_ Musculoskeletal \_\_\_\_ Neurological \_\_\_\_ Allergic

\_\_\_\_ Other, please note: \_\_\_\_\_

\_\_\_\_ No change in systems review

\_\_\_\_ Previous Past History reviewed and updated. Date of Past History update: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_ No change in Past History \_\_\_\_ See old Past History for changes

\_\_\_\_ Previous Social History reviewed and updated. Date of Social History updated: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_ No change in Social History \_\_\_\_ See old Social History for changes

\_\_\_\_ Previous Family History reviewed and updated. Date of Family History updated: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_ No change in Family History \_\_\_\_ See old Family History for changes

Doctor Signature: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

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P	N	Past Problem	When and Explanation of Condition
		Cancer	
		Balance Problems	
		Stroke	
		Thyroid Problems	
		Asthma	
		Heart Attack	
		HIV	
		Angina/Chest Pain	
		Diabetes	
		Gout	
		Broken Bones	
		Arthritis	
		Serious Depression	
		Other	

SURGERY	YES	NO	YEAR	SURGERY	YES	NO	YEAR
Tonsils				<b>WOMEN</b>			
Colon				Breast			
Hernia				Uterus			
Appendix				Ovaries			
Gall Bladder				<b>MEN</b>			
Stomach				Prostate			
Heart				Other			
Kidney							
Other							
<b>What other major injuries have you had?      Date</b>				<b>Have you ever taken:</b>			
				Insulin			
				Cortisone			
				Thyroid Medicine			
				Male/Female Hormones			
<b>What medications are you currently taking?      Date</b>				Blood Pressure			
				Tranquilizers/Sedatives			
				Birth Control			

**Hospitalizations:**


Doctor Signature: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

NAME:

DATE:

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Marital Status  Married  Divorced  Single  Separated  Widowed

Number of Children: \_\_\_\_\_

Frequency of Exercise  Never  Rarely  Occasionally  Moderately  Regularly

Intensity of Exercise  Low Level  Medium Level  High Level  Competition Level

Sufficient Rest  Never  Rarely  Occasionally  Moderately

Hours of Sleep \_\_\_\_\_  10 or more hours

Well balanced diet  Never  Rarely  Occasionally  Moderately

Do you smoke?  No  Occasionally  1 to 2  2 to 3  4 to 5  More than 5 packs/day

Do you drink caffeinated beverages?  
 No  Occasionally  1 to 2  2 to 3  4 to 5  More than 5 drinks/day

Do you drink alcoholic beverages?  
 No  Occasionally  1 to 2  2 to 3  4 to 5  More than 5 drinks/day

Have you ever used street drugs?  Yes  No

Hobbies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How did you hear about us? \_\_\_\_\_

If from advertisement:

1) Newspaper Insert? \_\_\_\_\_ Which Newspaper? \_\_\_\_\_

2) Free Report? \_\_\_\_\_

3) Infomercial? \_\_\_\_\_

4) Decompression? \_\_\_\_\_

5) Other \_\_\_\_\_

Billboard? \_\_\_\_\_

Yellow Pages? \_\_\_\_\_

Website? \_\_\_\_\_

Family or Friend? \_\_\_\_\_

Monthly Newsletter? \_\_\_\_\_

Doctor Signature: \_\_\_\_\_

Patient Signature: \_\_\_\_\_