MUST BE SCANNED INTO CHART

NAME: _____ DOB: ___/____/____ DATE: _____

CHIEF COMPLAINT

1. **What is your chief complaint? (check)**
   - ☐ Neck pain
   - ☐ Low back pain
   - ☐ Shoulder pain
   - ☐ Mid back pain
   - ☐ Arm pain
   - ☐ Leg / foot pain

2. **Approximately when did it start?**

3. **Did this begin gradually or suddenly?**

4. **Did a specific incident contribute to this issue(s)?** ☐ YES ☐ NO
   Explain:

5. **Is this a work related problem?** ☐ YES ☐ NO
   Date of Incident:

6. **Have you experienced the same or similar condition(s)?** ☐ YES ☐ NO
   Explain:

7. **Are able to pin point the exact location of your symptoms?**
   Explain:

8. **Do these symptoms radiate to any other part of your body?**
   Describe:

9. **How would you describe the sensation you feel? (check)**
   - ☐ Dull
   - ☐ Burning
   - ☐ Gnawing
   - ☐ Shooting
   - ☐ Sharp
   - ☐ Aching
   - ☐ Throbbing
   - ☐ Constricting

10. **Are you experiencing any numbness / tingling to other parts of your body? (check)**
    - ☐ Fingers
    - ☐ Arms
    - ☐ Hips
    - ☐ Toes
    - ☐ Hands
    - ☐ Shoulders
    - ☐ Legs
    - ☐ Feet

11. **How would describe the intensity of your pain? (check)**
☐ Mild ☐ Moderate ☐ Severe

12. **Has your condition been consistent or intermittent? (circle)**

13. **Has this condition:**
☐ Gotten worse ☐ Remained the same ☐ Improved

14. **Have you found anything that gives you relief?**
Explain: *(ex. certain positions, ice / heat, walking, etc.)*

15. **Have you found anything that makes it worse?**
Explain: (*ex. certain positions, activities, coughing, sneezing, bending, etc.)*

16. **Any change in body functions?**
Explain: *(ex. Urination, defecation, respiration, digestion, sexual activities, etc.)*

17. **How has this condition affected your daily activities?**

18. **Have you taken any medication for this condition?**
(Over the counter or prescribed) ***PLEASE LIST***

19. **Have you attempted a course of physical therapy for this condition?** ☐ YES ☐ NO
Did you have any relief of symptoms if so? ☐ YES ☐ NO

20. **Have you attempted a trial of injections for this condition?** ☐ YES ☐ NO
**If so, did you have ANY relief (lasting or immediate?)*
Explain:

21. **Are you a current tobacco user? (check)**
☐ Dipping ☐ Smoking ☐ Electronic "vaping"
**If so, how much?*
☐ 1 pack / can daily ☐ ½ pack / can daily ☐ 1 full tank daily ☐ ½ full tank daily