

CHIEF COMPLAINT – HISTORY OF PRESENT ILLNESS

Why are you here today? _____

Body area(s) involved: Neck___ Back___ Head___ Ribs___ Pelvis___ Upper Extremity___ Lower Extremity___

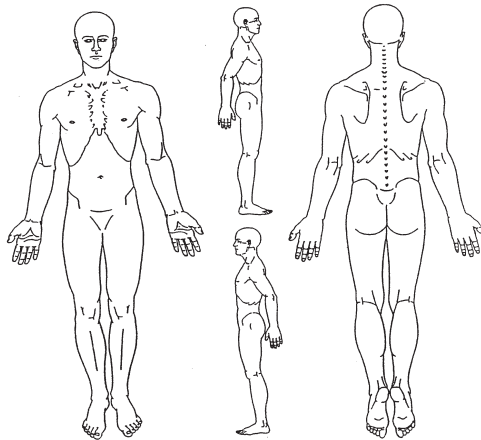
Is this condition: New___ Recurrence___ Exacerbation___ Chronic___

How did injury occur? Slip or Fall ___ Overexertion ___ Repetitive Use ___ Slept Wrong ___ No Injury ___

Is this injury: Work Related ___ Auto Related___ (You will need to fill in additional forms)

Use the letters below to indicate TYPE and LOCATION of your sensations right now:

- A=Aching
- B=Burning
- N=Numb
- P=Pain
- PN=Pins & Needles
- ST=Stabbing
- S=Stiffness
- W=Weakness



Level of pain at REST: 0__ 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__

Level of pain while ACTIVE: 0__ 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__

Feels worse in the: Morning___ Afternoon___ Night___

Feels worse with: Activity___ Sitting___ Standing___ Twisting___ Bending___ Walking___

Are you experiencing any of these symptoms?: Blurred Vision___ Dizziness___ Irritability/Mood Swings___ Chronic Fatigue___

Localized Tingling___ Nausea___ Ringing In Ears___ Sleep Disturbance___ Cold Limbs___ Ecchymosis___

Fever___ Heartburn___ Joint Stiffness___ Muscle Spasm___ Muscle Weakness___ Pale Bluish Skin___

Panic___ Runny Nose___ Shortness of Breath___ Sweating___ Swelling___ Vomiting___

Does the pain radiate? Left___ Right___ Both Sides___ No Radiation___

Is there weakness present? Left___ Right___ Both Sides___ No Weakness___

Symptoms better with? Nothing___ OTC Meds___ RX Meds___ Cold___ Heat___ Massage___

Movement___ Sitting___ Standing___ Stretching___ Walking___

Do you suffer from any conditions other than what is listed above? _____

CURRENT MEDICATIONS

Medication_____ Dosage_____ For Which Condition?_____ For How Long?_____

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HEADACHES

Are you here for headaches? Yes ___ No ___

Location: Occipital ___ Frontal ___ Left Temporal ___ Right Temporal ___ Parietal ___ Sinus ___

Quality: Dull ___ Sharp ___ Throbbing ___ Stabbing ___ Aura ___ No Aura ___

Types: Hat Band ___ Cluster ___ Migraine ___ Tension ___

Other: How often? _____ How long? _____ What time of day? _____

Does the pain radiate? Yes ___ No ___ If Yes: Left ___ Right ___ Both ___

Is body weakness present? Yes ___ No ___

FOOT PAIN

Are you here for foot pain? Yes ___ No ___

Location: _____

Quality: _____

HISTORY OF INJURIES Check ALL Injuries and Approximate Year

Back Injury _____ MVA _____ Broken Bones _____ Head Injury (loss of consciousness) _____

Head Injury (no loss of consciousness) _____ Soft Tissue Injury (mild) _____ Soft Tissue Injury (moderate) _____

Soft Tissue Injury (severe) _____ Fall(severe) _____ Joint Injury _____

Other _____

HISTORY OF SURGERIES List ALL Surgical Procedures and Approximate Year

SOCIAL HISTORY

Diet: No Specific Diet ___ High Fat ___ High Fibre ___ High Protein ___ Low Calorie ___ Low Carb ___ Low Salt ___ Other _____

Alcohol: Never ___ Social Only ___ How Many Drinks Per Week? ___

Tobacco: No tobacco Use ___ Live With A Smoker ___ Currently Smoke ___ How Many Per Day ___

FAMILY HISTORY (Check ALL that apply) List specific conditions.

Father: Alive ___ Deceased ___ No Significant Disease ___ Has/Had _____

Mother: Alive ___ Deceased ___ No Significant Disease ___ Has/Had _____

Brother(s): Alive ___ Deceased ___ No Significant Disease ___ Has/Had _____

Sister(s): Alive ___ Deceased ___ No Significant Disease ___ Has/Had _____

Son(s): Alive ___ Deceased ___ No Significant Disease ___ Has/Had _____

Daughter(s): Alive ___ Deceased ___ No Significant Disease ___ Has/Had _____

REVIEW OF ALL CURRENT HEALTH SYSTEMS

Constitutional: Chills___ Fatigue___ Night Sweats___ Weight Loss___ Daytime Drowsiness___ Fever___ Weight Gain___

I have none of the symptoms listed above___

Eyes & Vision: Wear Glasses/Contact___ Blindness___ Change In Vision___ Field of Vision Problems___ Light Sensitivity___

Blurred Vision___ Double Vision___ Glaucoma___ Tearing___ Cataracts___ Eye Pain___ Itching___

I have none of the symptoms listed above___

Ear/Nose /Throat: Ear Drainage___ Hearing Loss___ Ear Pain___ Ringing in the Ears___ Nosebleeds___ Post Nasal Drip___

Runny Nose___ Loss of Smell___ Nasal Congestion___ Snoring___ Frequent Sore Throat ___ Difficulty Swallowing___ Hoarseness ___

TMJ pain___ Dizziness ___ Headaches___

I have none of the symptoms listed above___

Respiration: Asthma___ Coughing up Blood___ Sputum Production___ Shortness of Breath___ Wheezing___

I have none of the symptoms listed above___

Cardiovascular: Angina___ High blood pressure___ Chest Pain___ Shortness of Breath With Exertion___ Low Blood Pressure___

Swelling of Legs___ Leg Pain with Activity___ Shortness of Breath Lying Down___ Heart Murmur___ Palpitations___

I have none of the symptoms listed above___

Gastrointestinal: Abdominal Pain___ Diarrhea___ Indigestion___ Vomiting Blood___ Belching___ Heartburn___ Nausea___ Ulcers___

Abnormal Stool Colour ___ Abnormal Stool Consistency___ Constipation___ Hemorrhoids___ Rectal Bleeding___

I have none of the symptoms listed above___

Females Only: Birth Control___ Cramps___ Irregular Menstruation___ Breast Lumps/Pain___ Frequent Urination___

Burning Urination___ Pregnancy___ Hormone Therapy

I have none of the symptoms listed above___

Males Only: Burning Urination___ Frequent Urination___ Prostate Problems___ Erectile Dysfunction___

I have none of the symptoms listed above___

Endocrine: Cold Intolerance___ Heat Intolerance___ Excessive Hunger___ Excessive Thirst___ Goiter___ Unusual Hair Growth___

Hair Loss___ Diabetes___

I have none of the symptoms listed above___

Skin: Changes in Nail Texture___ Itching___ Skin Lesions___ Changes in Skin Colour ___ Hives___ Varicosities___

I have none of the symptoms listed above___

Nervous System: Dizziness___ Limb Weakness___ Numbness___ Changes in Sensation___ Slurred Speech___ Tremor___

Facial Weakness___ Seizures___ Stress___ Unsteadiness___ Headache___ Memory Loss___ Sleep Disturbance___ Strokes___

I have none of the symptoms listed above___

Psychological: Behaviour Change___ Anxiety___ Depression___ Mood Change___ Insomnia___ Change in Appetite___

Confusion___

I have none of the symptoms listed above___

Allergy: Anaphylaxis ___ Rash___ Itching___ Nasal Congestion___ Sneezing___ Food Intolerance___

I have none of the symptoms listed above___

Hematologic: Anemia___ Blood Clotting___ Bruise Easily___ Lymph Node Swelling___ Bleeding___ Transfusion___

I have none of the symptoms listed above___