****

**History of Current Condition**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_\_\_\_**

**Have you seen another doctor for this condition? No Yes If yes, then Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Give details / Tests\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Female- To the best of my knowledge: I am not pregnant I am pregnant**

**What is your major complaint? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(use back side for additional complaints)**

**Date problem began? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How did this problem begin (falling, lifting, etc.)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you had this exact condition in the past? Yes No**

**How is your condition changing? Getting Better Getting Worse Not Changing**

**Is the pain on: Left Right Both Left/Right Center None**

**Please rate your symptoms on a scale of 1 to 10 (0= none and 10= excruciating) 1 2 3 4 5 6 7 8 9 10**

**What is the intensity? Minimal Mild Moderate Severe Unbearable None**

**Describe the nature of your symptoms: Sharp Dull Numb Burning Shooting Tingling Tightness Stabbing Throbbing Pressure Pinch Swelling Radiating Pain to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How often do you experience your symptoms? Constantly (76-100% of the day) Frequently (51-75% of the day)**

**Occasionally (26-50% of the day) Intermittently (0-25% of the day)**

**Currently, what is making your symptoms better? : Acupuncture Chiropractic Therapy Heat Ice Massage Pain Medicines Physical Therapy Sleep/Rest Stretching Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nothing Helps**

**What activities aggravate your condition (working, exercise, etc)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### Please mark your area of pain on the diagram below

### Patient History photo

**If you are an established patient are there any changes in your medical history since your last visit?**

**Yes No**

**If so explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**(See back for more conditions)**