Current Health Condition

Name: ______________________________ Date: ______________

Chief Complaint: ______________________________

When did it start? ______________ How did it begin? ☐ Gradually ☐ Suddenly

Did anything cause it or contribute to its onset? ______________________________

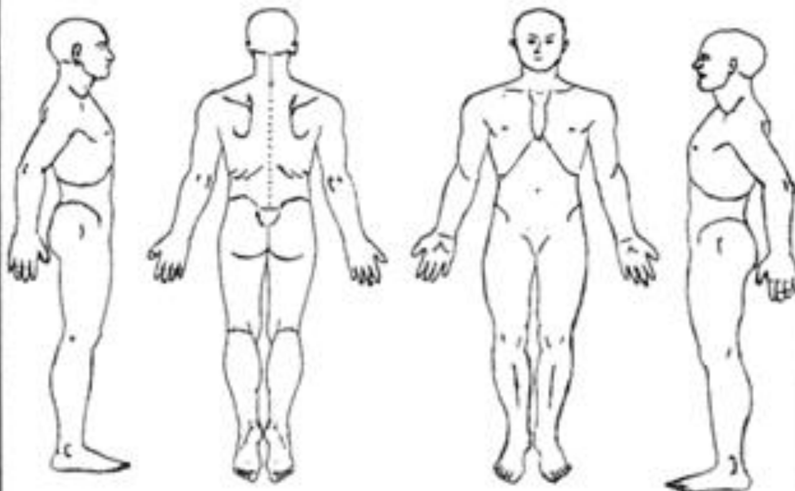
Have you had this before? ☐ Yes ☐ No If so, when? ______________

What did you do for it then, and did it help? ______________________________

Did you see anyone for it? ☐ Yes ☐ No If yes, who? ______________

Are you currently under anyone else's care? ☐ Yes ☐ No If so, who?

Indicate where you have pain or other symptoms:



What decribes the nature of your symptoms?

☐ Sharp ☐ Shooting
☐ Dull Ache ☐ Burning
☐ Numbness ☐ Tingling

How often do you experience your symptoms?

☐ Constantly (from 76% to 100% of the day)
☐ Frequently (from 51% to 75% of the day)
☐ Occasionally (from 26% to 50% of the day)
☐ Intermittently (from 1% to 25% of the day)

When are your symptoms worse?

☐ Morning ☐ Afternoon
☐ Evening ☐ During the Night

Does it radiate to other parts of your body? ☐ Yes ☐ No If so, to where? ______________

Which activities make it better? ______________________________

Which activities make it worse? ______________________________

Circle the number that represents how bad your symptoms are at their:

Worst:	None	1	2	3	4	5	6	7	8	9	10	unbearable
Best:	None	1	2	3	4	5	6	7	8	9	10	unbearable

How are your symptoms changing? ☐ Getting Better ☐ No Change ☐ Getting Worse

How do your symptoms affect your ability to perform daily activities?

☐ Not at all ☐ Limiting, prevents full activity
☐ Mild, forgotten with activity ☐ Intense, preoccupied with seeking relief
☐ Moderate, interferes with activity ☐ Severe, no activity possible

Do you have symptoms in any other part of your body, or a change in any bodily function? ☐ Yes ☐ No

If yes, please explain: ______________________________

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______________________________ ______________
Patient's Signature (or parent's signature) Date