Patient's Present Complaints

Name:_____Date: _____

Please check all answers and fill in the blanks where appropriate. Describe your present complaint. This information is necessary to assist the doctor in understanding your health condition.

Please describe your problem and how it began. **What part of the body is affected?** Date problem began: _____

_____

_____

_____

How bad is your pain? (circle a number) 0 1 2 3 4 5 6 7 8 9 10
No pain Unbearable Pain

Are you pregnant now? _____ **How many pregnancies**? _____ **How Many Births? _____**

How often are your symptoms present?	☐ Constantly	☐ Frequently	☐Occasionally
Describe your <u>current</u> pain/symptoms:	☐ Sharp/Stabbing	☐ Throbbing	☐ Aches
	☐ Dull	☐ Soreness	☐ Weakness
	☐ Numbness	☐ Shoot	☐ Gripping
	☐ Burning	☐ Tingling	☐ Other _____
Since it began, is your problem…	☐ Improving	☐ Getting Worse	☐ No Change
What make the problem worse?	☐ Nothing	☐ Lying Down	☐ Walking
	☐ Standing	☐ Sitting	☐ Movement
Can you perform your daily living activities?	☐ Yes	☐ Yes, only with help	☐ Not at all
Do you exercise?	☐ Yes, almost daily	☐ Yes, occasionally	☐ Not at all
Describe your job description:	☐ Mainly Sitting	☐ Light Labor	☐ Heavy Labor
Can you perform daily work duties?	☐ Yes, all activities	☐ Only some	☐ Not at all
Describe your stress level:	☐ None to mild	☐ Moderate	☐ High

What treatment have you had for this condition in the past? (Surgery, medications, injections, chiropractic, etc.)

_____

_____

Have you had X-Rays, MRI or other tests for this condition? What and When? _____

_____

Please continue to next page fore the General Health Questionnaire…

Treating Dr.'s Initials_____

If you have ever listed a symptom in the past, please check that symptom in the "past" column. If you are presently troubled by a particular symptom, check that symptom in the "Present" column.

KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT OR THERAPY YOU RECEIVE

Patient Name:_____Present Weight: _____lbs. Height: _____feet _____inches

PAST	PRESENT	CONDITION	PAST	PRESENT	CONDITION
☐	☐	Neck Pain	☐	☐	Depression
☐	☐	Shoulder Pain R_____ L_____	☐	☐	Aortic Aneurysm
☐	☐	Pain in Upper Arm or Elbow R____ L____	☐	☐	High Blood Pressure
☐	☐	Hand Pain R____ L ____	☐	☐	Angina
☐	☐	Wrist Pain R____ L ____	☐	☐	Asthma
☐	☐	Upper Back Pain	☐	☐	Prostate Problems
☐	☐	Low Back Pain	☐	☐	Blood Disorder
☐	☐	Pain in Upper Leg or Hip R____ L____	☐	☐	Emphysema
☐	☐	Pain in Lower Leg or Knee R____ L____	☐	☐	Chronic Lung Disorders
☐	☐	Pain in Ankle or Foot R____ L ____	☐	☐	Arthritis
☐	☐	Jaw Pain	☐	☐	Rheumatoid Arthritis
☐	☐	Swelling or Stiffness of Joints	☐	☐	Diabetes
☐	☐	Fainting	☐	☐	Epilepsy
☐	☐	Visual Disorders	☐	☐	Ulcer
☐	☐	Convulsions	☐	☐	Liver/Gallbladder Problems
☐	☐	Dizziness	☐	☐	Kidney Stones
☐	☐	Headaches	☐	☐	Colitis
☐	☐	Muscular incoordination ☐	☐		Irritable Colon
☐	☐	Tinnitus (Ear Noises, ringing)	☐	☐	HIV/AIDS
☐	☐	Rapid Heart Beat	☐	☐	Loss of Bladder Control
☐	☐	Chest Pains	☐	☐	Painful Urination
☐	☐	Loss of Appetite	☐	☐	Frequent Urination
☐	☐	Anorexia	☐	☐	Abdominal Pain
☐	☐	Abnormal Weight ___Gain ___Loss	☐	☐	Constipation/Irregular Bowel Habits
☐	☐	Excessive Thirst	☐	☐	Difficulty in Swallowing
☐	☐	Chronic Cough	☐	☐	Heartburn/Indigestion
☐	☐	Chronic Sinusitis	☐	☐	Dermatitis/Eczema/Rash
☐	☐	General Fatigue	☐	☐	Irregular Menstrual Flow
☐	☐	Breast - Soreness___Lumps _____	☐	☐	Profuse Menstrual Flow
☐	☐	Endometriosis	☐	☐	PMS

Heart Attack? Date _____

Cancer? Type & Date _____

Tumor? Type & Date _____

Stroke? Date _____

Do you have a Permanent Disability Rating? Y____ N_____

If yes, location: _____

Date Rating Received _____ Rating Percent _____%

If any family member has had any of the following, please mark the appropriate box:

☐ Cancer ☐ Lupas

☐ Heart Problems ☐ Lung Problems

☐ Rheumatoid Arthritis ☐ Diabetes

☐ Chronic Back Problems ☐ Epilepsy

☐ Chronic Headaches High Blood Pressure

☐ Other _____

Please check any of the following that apply to you:

Birth Control Pills (type) _____

Coffee/Tea/Caffeinated Soft Drinks: cups/can per day: _____

Tobacco Use: Past _____ Present:_____

Drug or Alcohol Dependency: Past_____ Present _____

Alcohol Use: Past _____ Present _____

Hospitalizations/Surgeries: _____

Medications: _____

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify the doctor immediately whenever I have changes in my health condition or heath plan coverage in the future.

Patient Signature:_____