

CURRENT COMPLAINT HISTORY (PATIENT)

Patient Name: _____

Date: _____

Please check all boxes that apply to your condition and fill in the spaces that describe your present complaint(s). Also, the information you provide concerning **past** symptoms will help in assisting the doctor to better understand your present complaints and **total** health picture.

Please list your present complaint(s) and mark your level of pain today for each complaint – If you have more than one area of complaint, list them in order of most severe to least severe.

1. _____ Duration – (How Long / Date): _____ # of Previous Episodes: _____
(Please circle one.) (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)
2. _____ Duration – (How Long / Date): _____ # of Previous Episodes: _____
(Please circle one.) (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)
3. _____ Duration – (How Long / Date): _____ # of Previous Episodes: _____
(Please circle one.) (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

Has anyone treated you for this episode? Yes No If yes, by whom? _____

How did your **symptoms begin**?

- Immediately after a specific incident After multiple incidents Gradually developed over time Other _____

What makes your **symptoms better**?

- Nothing Lying down Standing Sitting Movement/Exercise Other _____

What makes your **symptoms worse**?

- Nothing Lying down Standing Sitting Movement/Exercise Other _____

Are your **symptoms**?

- Decreasing Increasing
 Not Changing Other _____

Description of pain or symptoms:

- Sharp Shooting
 Dull Burning
 Ache Numb
 Weakness Tingling
 Throbbing Other _____

Does your pain **move** or **radiate**?

- Yes No Where _____

Check the best and worse times of the day for your pain:

- | | |
|--------------------------------------|--------------------------------------|
| Worse | Best |
| <input type="checkbox"/> First Awake | <input type="checkbox"/> First Awake |
| <input type="checkbox"/> Morning | <input type="checkbox"/> Morning |
| <input type="checkbox"/> Afternoon | <input type="checkbox"/> Afternoon |
| <input type="checkbox"/> Evening | <input type="checkbox"/> Evening |
| <input type="checkbox"/> Nighttime | <input type="checkbox"/> Nighttime |
| <input type="checkbox"/> Other | <input type="checkbox"/> Other |

Frequency of pain or symptoms:

- Constant (76 – 100%)
 Frequent (51 – 75%)
 Occasional (26 – 50%)
 Intermittent (25% or less)

SHOW US YOUR PAIN
USE THE LETTERS BELOW TO INDICATE THE TYPE
AND LOCATION OF YOUR SYMPTOMS TODAY

*KEY: A = ACHE B = BURNING N = NUMBNESS P = PINS & NEEDLES
S = STABBING X = STIFFNESS T = THROBBING O = OTHER

How many days out of **an average week** are you in **pain**? (Please circle one.) 1 2 3 4 5 6 7

How much time during the **day** are you in **pain**?

- less than 1 hour 1 to 6 hours 6 to 12 hours 12 to 18 hours 18 to 24 hours 24 hours

Patient's/Guardian's Signature: _____

Date: _____