**Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Detailed History:**

**Chief Complaint(s): (location, quality, severity, duration, timing, context, modifying factors, associated sings & symptoms}**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Major Complaints** | For how long?  | How often? | Duration | Any Diagnosis? |
| **1.** |  |  |  |  |  |
| **2.** |  |  |  |  |  |
| **3.** |  |  |  |  |  |
| **4.** |  |  |  |  |  |
| **5.** |  |  |  |  |  |

 **Other Complaints**

|  |
| --- |
|  |

**Please explain when did the problem begin?**

**To what extent does the problem interfere with your daily activity (work, exercise, sleep, sex, etc.)?**

**My Pain/Condition is**:

Constant Frequent Intermittent Occasional



□ X: Pain □ Tt: Tight □ B: Burning □ Tg: Tingling □ N: Numbness □ Sp: Spasm □ W: Weakness

□ H: Heavy □ Sw: Swelling □Th: Throbbing □ D: Dull □ S: Stabbing □ J: jabbing □ B: Bouts

□ Td: Tenderness:

**Pain Scale**

None Minimal Slight Moderate Severe Pain

0 1 2 3 4 5 6 7 8 9 10

**The pain is associated with**

□ Stress □ Tension □ Depression □ Anxiety □ other

None Minimal Slight Moderate Severe Pain

0 1 2 3 4 5 6 7 8 9 10

**The location of pain in more details**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Location of Pain | Level (1-10) | Frequency of Pain Episodes | Aggravating Factors | Relieving Factors | Radiation | Special Times of occurrence | Frequency | Duration |
| Face |  |  |  |  |  |  |  |  |
| Headache |  |  |  |  |  |  |  |  |
| Jaw |  |  |  |  |  |  |  |  |
| Upper back |  |  |  |  |  |  |  |  |
| Middle back |  |  |  |  |  |  |  |  |
| Lower back |  |  |  |  |  |  |  |  |
| Chest |  |  |  |  |  |  |  |  |
| Neck |  |  |  |  |  |  |  |  |
| Shoulders |  |  |  |  |  |  |  |  |
| Upper Arm |  |  |  |  |  |  |  |  |
| Elbows |  |  |  |  |  |  |  |  |
| Forearm |  |  |  |  |  |  |  |  |
| Wrists |  |  |  |  |  |  |  |  |
| Hands |  |  |  |  |  |  |  |  |
| Fingers |  |  |  |  |  |  |  |  |
| Buttocks |  |  |  |  |  |  |  |  |
| Hip |  |  |  |  |  |  |  |  |
| Thighs |  |  |  |  |  |  |  |  |
| Knees |  |  |  |  |  |  |  |  |
| Legs |  |  |  |  |  |  |  |  |
| Ankles |  |  |  |  |  |  |  |  |
| Foot |  |  |  |  |  |  |  |  |
| Toes |  |  |  |  |  |  |  |  |