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.					

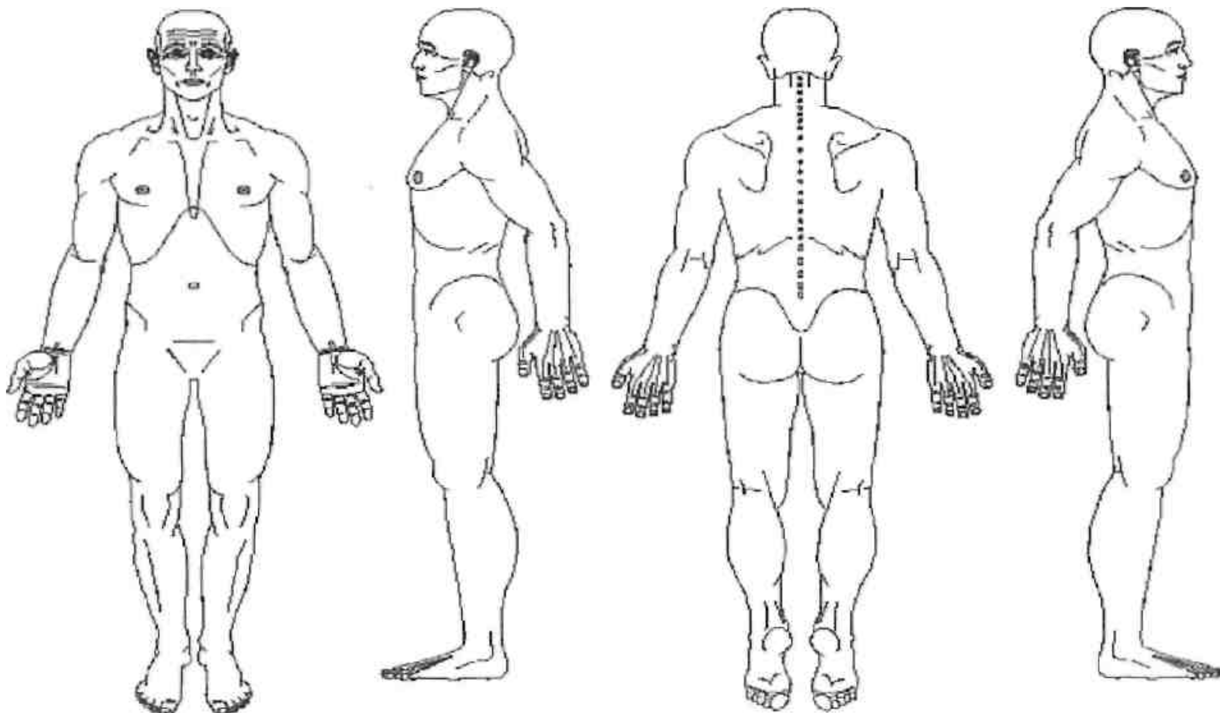
Other Complaints

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								