History of Present Illness:

Patient name: _____ Age: _____

Sex ◻ M ◻ F Are you ◻ Right handed ◻ Left handed Job title and description: _____

Date of Injury: _____

Were you sent to our office by a physician? ◻ Yes ◻ No Physician's name: _____ Phone: _____

Have you seen any other physician for this problem? ◻ Yes ◻ No Their name: _____

Why are you here today? _____
Brief description

Location of problem? _____ Cause/context: _____
Site of problem. Where is it? What caused discomfort to begin?

Quality? _____ _____
Describe discomfort (sharp, dull, achy, weakness, giving away, catching, burning) Improving, same, getting worse

Severity of pain? ◻ 1 ◻ 2 ◻ 3 ◻ 4 ◻ 5 Does the pain travel? _____ Duration: _____
Body location (infrequent, intermittent, occasional, frequent , constant)

Modifying Factors: What makes discomfort better? _____ makes it worse? _____

Associated signs/symptoms: _____
Any other associated symptoms, numbness, tingling, swelling, weakness, instability

Review of systems:

◻ Reading Glasses	◻ Toothache	◻ Frequent Headaches
◻ Change of Vision	◻ Gum Trouble	◻ Blackouts
◻ Loss of Hearing	◻ Nausea or Vomiting	◻ Seizure
◻ Ear Pain	◻ Stomach Pain	◻ Frequent Rash
◻ Hoarseness	◻ Ulcers	◻ Hot or Cold Spells
◻ Nosebleeds	◻ Frequent Belching	◻ Recent Weight Change
◻ Difficulty Swallowing	◻ Frequent Diarrhea	◻ Nervous Exhaustion
◻ Morning Cough	◻ Frequent Constipation	WOMEN ONLY
◻ Shortness of Breath	◻ Hemorrhoids	◻ Irregular Periods
◻ Fever or Chills	◻ Frequent Urination	◻ Vaginal Discharge
◻ Heart or Chest Pain	◻ Burning on Urination	◻ Frequent Spotting
◻ Abnormal Heartbeat	◻ Difficulty starting Urination	◻ Other
◻ Swollen Ankles	◻ Get up more than once for urination during the night	
◻ Calf Cramps with Walking		
◻ Poor Appetite		

Additional space for comments: _____