

CONFIDENTIAL MEDICAL HISTORY of _____

(Name)

CHIEF COMPLAINT Please describe the problem which brings you in, as completely as possible.

If there are several "chief complaints" then please list them below with the most bothersome first then fill in the form going through one complaint at a time using a separate section to describe each.

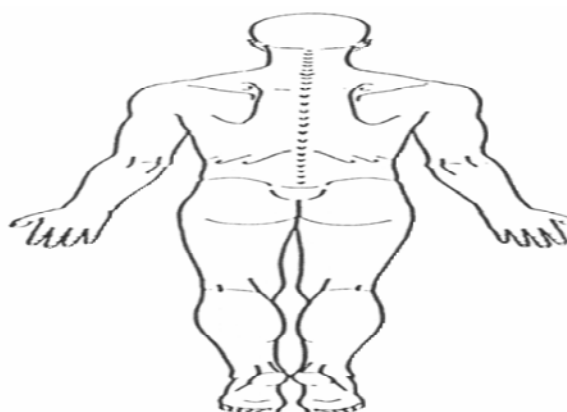
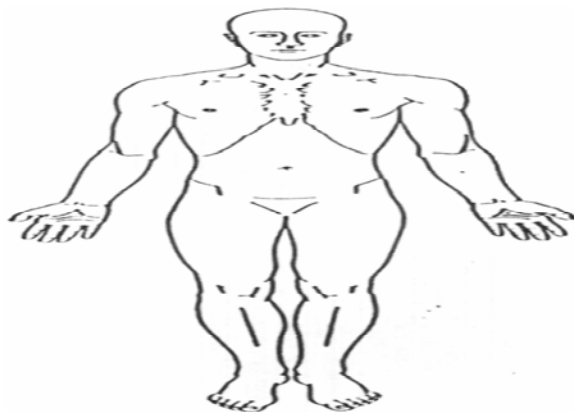
1. **Primary complaint** _____

2. **Secondary complaint** _____

3. **Third complaint** _____

4. **Other complaints** _____

MARK PAIN AREA



Primary Complaint (describe in detail) _____

1. **When did you first notice the problem?**

A) Approximate Month / Day / Year ____ / ____ / ____

B/ Approximately with the last: 1-3 months ____, 6-12 months ____, 1-2 years ____,
3-5 years ____, 5 or more years ____, How many years? ____

2. **When did the problem last occur?** ____ / ____ / ____

3. **How did the problem originally occur?** A) Suddenly ____ B) Gradually ____

4. **What do you think caused the problem to occur?**

Accident/Injury

Physical Stress

Environmental Stress

Unknown

Mental/Emotional Stress

Fatigue/Energy Stress

Nutritional Stress

Repetitive Use/Abuse

Other Disease/Condition

Describe _____

5. How long does an episode last? (Specify duration as best you can.)

Minutes Intermittent Hours Constant

6. Does the problem tend to occur at a certain time(s) of day?

Y / N Time(s) _____

7. Does the problem tend to occur or become aggravated by weather, seasons, or seasonal changes? Y / N Explain _____

8. What if anything, provokes or worsens the problem? Sitting Standing Walking

Bending Stairs (Ascending) Stairs (Descending) Running Eating

Lying Down Fatigue Sleeping Movements

Other/Explain _____

9. What movements or actions make the problem better? _____

10. Please describe the severity pain/discomfort associated with the problem:

A. mild B. moderate C. considerable D. severe

11. Please describe the quality or character of pain/discomfort associated with the problem:

sharp stabbing radiating searing stitching

burning throbbing aching deep aching boring

band-like hot poker itching constant intermittent

occasional In your own words _____

12. Have you seen other doctors, clinics or hospitals for this complaint? Y / N

Name _____

Name _____

Address _____

Address _____

Phone () _____ - _____

Phone () _____ - _____

Dates Seen _____

Dates Seen _____

13. Have any of these seemed to help? Y / N Which ones helped and how? _____

14. Have you tried any over the counter or prescription drugs or preparations for this condition? Y / N Please list _____

15. Have you tried any nutritional, homeopathic or herbal remedies? Y / N Please list _____

16. Have any of these seemed to help? Y / N Which ones helped and how? _____

17. Please describe any other symptoms you associate with this complaint. _____

(Page 2) **CONFIDENTIAL MEDICAL HISTORY** of _____
(Name)

Secondary Complaint (describe in detail) _____

1. When did you first notice the problem?

A) Approximate Month / Day / Year _____ / _____ / _____

B/ Approximately with the last: 1-3 months _____, 6-12 months _____, 1-2 years _____,
3-5 years _____, 5 or more years _____, How many years? _____

2. When did the problem last occur? _____/_____/_____

3. How did the problem originally occur? A) Suddenly _____ B) Gradually _____

4. What do you think caused the problem to occur?

- | | | |
|---|--|--|
| <input type="checkbox"/> Accident/Injury | <input type="checkbox"/> Physical Stress | <input type="checkbox"/> Environmental Stress |
| <input type="checkbox"/> Unknown | <input type="checkbox"/> Mental/Emotional Stress | <input type="checkbox"/> Fatigue/Energy Stress |
| <input type="checkbox"/> Nutritional Stress | <input type="checkbox"/> Repetitive Use/Abuse | <input type="checkbox"/> Other Disease/Condition |

Describe _____

5. How long does an episode last? (Specify duration as best you can.)

Minutes Intermittent Hours Constant

6. Does the problem tend to occur at a certain time(s) of day?

Y / N Time(s) _____

7. Does the problem tend to occur or become aggravated by weather, seasons, or seasonal changes? Y / N Explain _____

8. What if anything, provokes or worsens the problem? Sitting Standing Walking

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Lying Down Fatigue Sleeping Movements

Other/Explain _____

9. What movements or actions make the problem better? _____

10. Please describe the severity pain/discomfort associated with the problem:

A. mild B. moderate C. considerable D. severe

