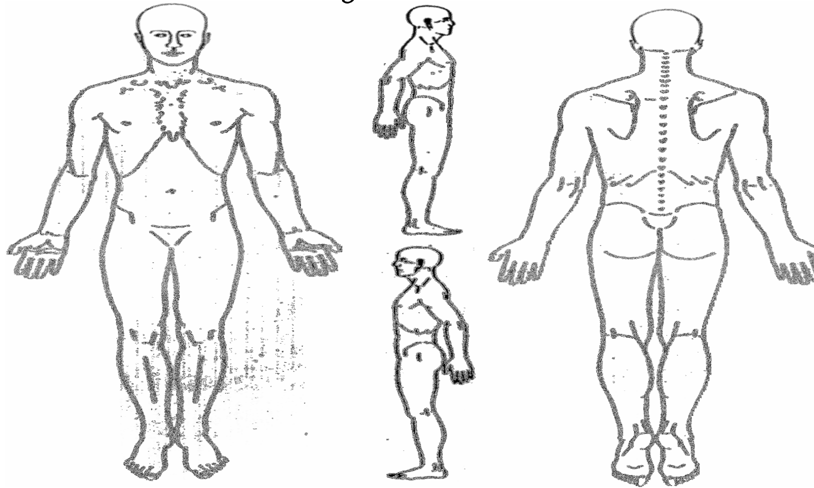
CONFIDENTIAL MEDICAL HISTORY

If there is several "chief complaints" then please list them below with the most bothersome first then fill in the form

1. Primary Complaint:____
2. Other Complaints:____

____

Mark your affected area



Please describe in detail your Primary Complaint:______________________________

____

____

Please describe in detail Other Complaints:__________________________________

____

____

1. When did you first notice the Primary problem?

   Approx. Date: _____/_____/_____

   Approx in the Last : ☐ 1-3 Months ☐ 6-12 Months ☐ 1-2 Years

   ☐ 3-5 Years ☐ 5 or more ☐ Other___________

2. How did the problem originally occur?

Suddenly ☐ Gradually ☐

3. When did the problem last occur?

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

☐ Accident/Injury ☐ Physical Stress ☐ Repetitive /Abuse

☐ Mental /Emotional Stress ☐ Fatigue/Energy Stress ☐ Unknown

☐ Nutritional Stress ☐ Environmental Stress ☐ Other Disease/Condition

Describe:____

____

5. How long does the episode last?

Approx. ☐ Minutes ☐ Hours

☐ Intermittent ☐ Constant

6.Does the problem tend to occur at a certain time of day? ☐ Yes ☐ No

Time(s) ____

7. Does the Weather, Seasons, or seasonal change tend to cause the problem and or irritate the problem?

☐ Yes ☐ No

Describe:____

____

8. Which of the following describes the severity of pain /discomfort?

☐ Mild ☐ Moderate ☐ Considerable ☐ Severe

9. Of the following please check the ones that provokes or worsen the problem:

☐ Bending ☐ Sitting ☐ Standing ☐ Walking ☐ Stairs (Descending)

☐ Running ☐ Fatigue ☐ Lying Down ☐ Sleeping ☐ Stairs (Ascending)

☐ Eating ☐ Movement

☐ Other/ Explain____

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

☐ Sharp ☐ Stabbing ☐ Radiating ☐ Searing ☐ Stitching

☐ Hot poker ☐ Throbbing ☐ Aching ☐ Itching ☐ Boring

☐ Band-Like ☐ Burning ☐ Deep Aching ☐ Constant ☐ Intermittent

☐ Occasional Other/ Explain____

11. Does any movements or actions make the problem better? Explain:______________________

____

12. Have you seen any Doctors, Clinics or Hospitals for this complaint? Y/N

Name_____________________________ Name_____________________________

Address___________________________ Address___________________________

____

____

Phone(   )____-________ Phone(   )____-________

13. If you have seen other Doctors, did they help? Y/N Which ones and how?__________________

____

14. What kind of over the counter or prescriptions drugs have you used for this condition?___________

____

15. Have you tried any Nutritional, Homeopathic or Herbal Remedies?______________________

____

16. Have any of these seemed to help? Which ones and how:___________________________

____