Central DuPage Physical Medicine

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PATIENT HISTORY

Chief Complaint : _____ When did it start? _____

Circle the current pain level of your complaint:

1	2	3	4	5	6	7	8	9	10

Mild Severe

Circle the percentage of day you experience the complaint:

10	20	30	40	50	60	70	80	90	100

Has the pain ever been a level 9 or 10? ❑ Yes ❑ No

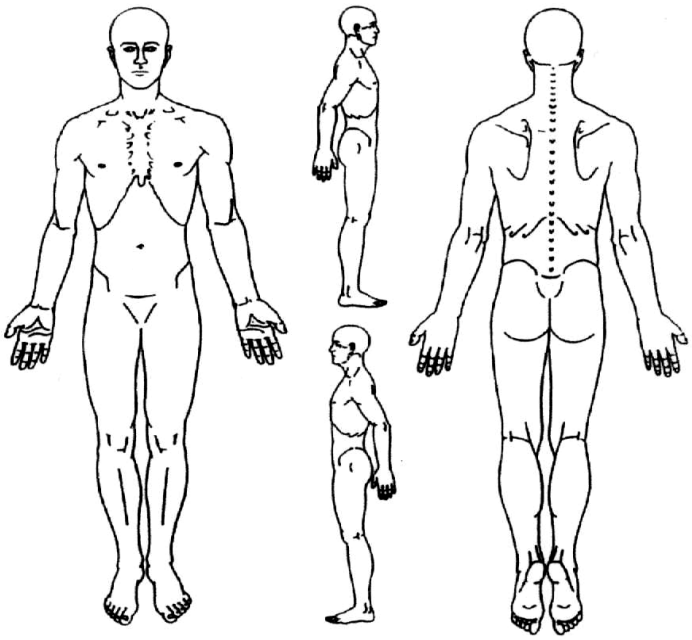
When do you feel it most? ❑ AM ❑ PM When present, how long does the complaint last? _____ Mins _____ Hrs

What makes it feel better? _____ What makes it feel worse? _____

Note: If you need additional sheets, please ask the front desk.

Using the letters below, please show **where** you are experiencing **all** of your current complaints:

A: Ache
B: Burning
C: Cramping
D: Dull Pain
F: Stiffness
N: Numbness
R: Throbbing
S: Soreness
T: Tingling
X: Sharp Pain



Do you currently have pain and/or difficultly performing any of the following activities? (Circle Y or N)

Walking	Y	N
Standing	Y	N
Running	Y	N
Sleeping	Y	N
Driving	Y	N
Personal Grooming	Y	N
Sitting	Y	N
Kneeling	Y	N
Exercising	Y	N
Bending	Y	N
Lifting Objects	Y	N
Lifting Children	Y	N
Housework	Y	N

1. Have you ever had the condition(s) in the past? ❑ Yes ❑ No If yes, please indicate what sort of treatment have you ever had: ❑ Hospitalization ❑ Chiropractic care ❑ Medical doctor / Specialty provider ❑ None
2. Have you ever lost work due to your condition(s)? ❑ Yes ❑ No If Yes, dates? _____
3. Are you pregnant? ❑ Yes ❑ No Number of pregnancies? _____ Number of miscarriages? _____
4. What was the first day of your last menstrual cycle? _____

In the event we can help, please indicate to us what your level of commitment would be to correcting your problem(s)?

Low Medium High

0	1	2	3	4	5	6	7	8	9	10

Patient Name (please print): _____ Account # _____

Patient Signature _____ Date: _____

Note: This is a confidential record and will be kept in this office. Information contained here will not be released to anyone without authorization to do so.