



CURRENT COMPLAINT HISTORY (PATIENT)

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please check all boxes that apply to your condition and fill in the spaces that describe your present complaint(s). Also, the information you provide concerning past symptoms will help in assisting the doctor to better understand your present complaints and total health picture.

Please list your present complaint(s) and mark your level of pain today for each complaint – If you have more than one area of complaint, list them in order of most severe to least severe.

- 1. \_\_\_\_\_ Duration – (How Long / Date): \_\_\_\_\_ (Please circle one.) (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable) # of Previous Episodes: \_\_\_\_\_
2. \_\_\_\_\_ Duration – (How Long / Date): \_\_\_\_\_ (Please circle one.) (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable) # of Previous Episodes: \_\_\_\_\_
3. \_\_\_\_\_ Duration – (How Long / Date): \_\_\_\_\_ (Please circle one.) (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable) # of Previous Episodes: \_\_\_\_\_

Has anyone treated you for this episode? Yes No If yes, by whom? \_\_\_\_\_

How did your symptoms begin?

- Immediately after a specific incident After multiple Incidents Gradually developed over time Other \_\_\_\_\_

What makes your symptoms better?

- Nothing Lying down Standing Sitting Movement/Exercise Other \_\_\_\_\_

What makes your symptoms worse?

- Nothing Lying down Standing Sitting Movement/Exercise Other \_\_\_\_\_

Are your symptoms?

- Decreasing Increasing Not Changing Other \_\_\_\_\_

Does your pain move or radiate?

- Yes No Where \_\_\_\_\_

Description of pain or symptoms:

- Sharp Shooting Dull Burning Ache Numb/Tingling Weakness Stiff Throbbing Other \_\_\_\_\_

Check the best and worse times of the day for your pain:

Table with 2 columns: Best, Worst. Rows: First Awake, Morning, Afternoon, Evening, Nighttime, Other.

Frequency of pain or symptoms:

- Constant (76 – 100%) Frequent (51 – 75%) Occasional (26 – 50%) Intermittent (25% or less)

How many days out of an average week are you in pain? (Please circle one.) 1 2 3 4 5 6 7

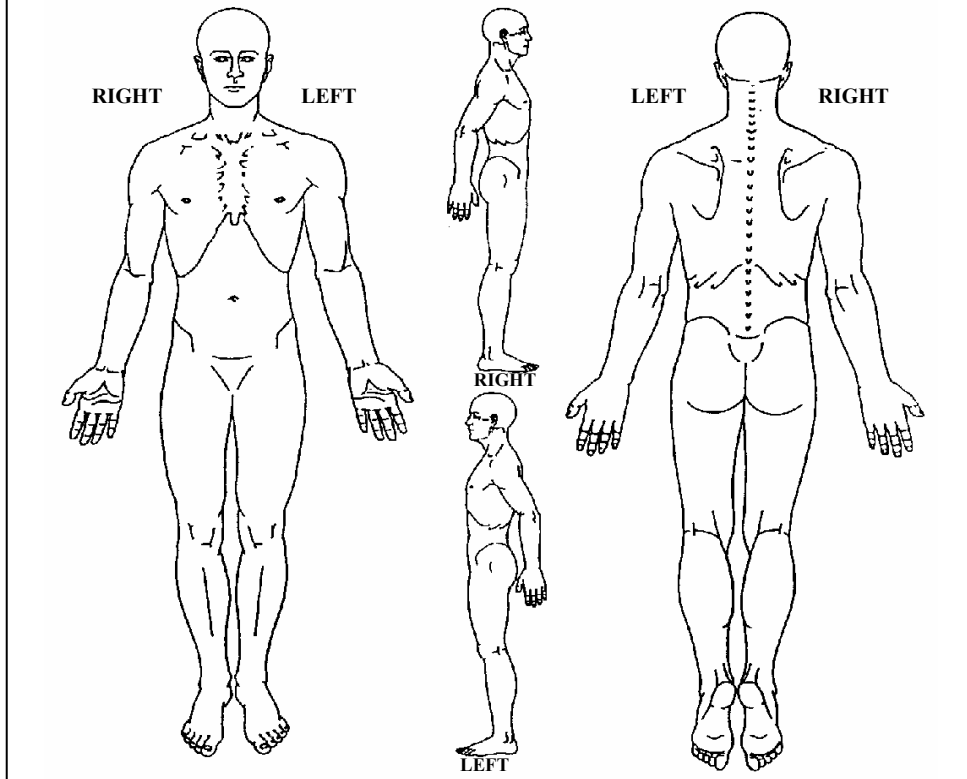
How much time during the day are you in pain?

- less than 1 hour 1 to 6 hours 6 to 12 hours 12 to 18 hours 18 to 24 hours 24 hours

Patient's/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

SHOW US YOUR PAIN  
USE THE LETTERS BELOW TO INDICATE THE TYPE  
AND LOCATION OF YOUR SYMPTOMS TODAY

KEY: A = ACHE      B = BURNING      N = NUMBNESS      P = PINS & NEEDLES  
S = STABBING      X = STIFFNESS      T = THROBBING      O = OTHER



Patient's/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_