CHIEF COMPLAINT FORM

NAME____ DATE____________________

WHAT IS YOUR **MAIN** COMPLAINT TODAY?

____

HOW LONG HAVE YOU HAD THIS CONDITION? ____

HOW DID THIS CONDITION BEGIN? ____

____

IS THERE ANYTHING THAT WILL MAKE THIS CONDITION BETTER? ________________________

IS THERE ANYTHING THAT WILL MAKE THIS CONDITION WORSE? _________________________

IS THERE ANY PART OF THE DAY THAT YOUR CONDITION IS BETTER? _____________________

IS THERE ANY PART OF THE DAY THAT YOUR CONDITION IS WORSE? _____________________

HAS YOUR CONDITION BEEN CONSTANT OR DOES IT COME AND GO? _____________________

HAVE YOU SEEN ANY OTHER HEALTH CARE PRACTITIONER FOR THIS CONDITION? IF SO, WHO AND WHEN?

____

____

IF THERE IS PAIN INVOLVED, ON A SCALE OF 1 – 10 (10 BEING THE WORST POSSIBLE PAIN YOU CAN THINK OF), HOW WOULD YOU RATE THIS PAIN:

RIGHT NOW? ______/10 **THE WORST POINT?** ______/10 **THE BEST POINT?** ______/10

IS THIS PAIN/SENSATION: (PLEASE CIRCLE)

SHARP **STABBING** **DULL** **ACHY** **THROBBING** **TINGLING** **STIFF** **BURNING** **NUMB**

PLEASE INDICATE THE AREA OF COMPLAINT (IF APPLICABLE):