

# HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS (Please describe)

Major Complaint: \_\_\_\_\_

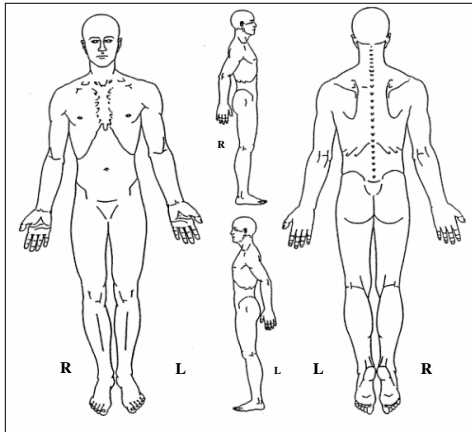
Secondary Complaints: \_\_\_\_\_

When did it start? \_\_\_\_/\_\_\_\_/\_\_\_\_ What happened? \_\_\_\_\_

Which daily activities are being affected by this condition? \_\_\_\_\_

## MAJOR COMPLAINT

### Location of Symptoms and Radiation



P \_\_ Pain                      T \_\_ Tender  
 N \_\_ Numb                     H \_\_ Hypoesthesia  
 S \_\_ Spasm

### Grade Intensity/Severity:

- None (0/10)
- Mild (1-2/10)
- Mild-Moderate (2-4/10)
- Moderate (4-6/10)
- Moderate-Severe (6-8/10)
- Severe (8-10/10)

### Frequency:

- Off & On
- Constant

### Quality:

- Sharp
- Stabbing
- Burning
- Achy
- Dull
- Stiff & Sore
- Other: \_\_\_\_\_

### Does it radiate?

- No     Yes (Please indicate on drawing)

### Improves with:

- Ice
- Heat
- Movement
- Stretching
- OTC Medications: \_\_\_\_\_
- Other: \_\_\_\_\_

### Worsens with:

- Sitting
- Standing/Walking
- Lying Down/Sleeping
- Overuse/Lifting
- Other: \_\_\_\_\_

### Previous Treatment:

- None
- Chiropractor \_\_\_\_\_
- Medical Doctor \_\_\_\_\_
- Physical Therapy \_\_\_\_\_
- ER/Urgent Care \_\_\_\_\_
- Orthopedic \_\_\_\_\_
- Other: \_\_\_\_\_

### Previous Diagnostic Testing:

- None
- X-rays \_\_\_\_\_
- MRI \_\_\_\_\_
- CT \_\_\_\_\_
- Other: \_\_\_\_\_

### \*Women: Are you pregnant?

- No    Last Menstrual Period: \_\_\_\_/\_\_\_\_/\_\_\_\_
- Yes                      Due date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Present Illness Comments:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Prescription Medications & Supplements:     None

Yes (List - Name, dosage, frequency) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Allergies to Medications:     No known drug allergies

Yes (List - Name and reaction) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name: (First MI Last) \_\_\_\_\_

Account No: \_\_\_\_\_