Patient Present Illness/Injury Questionnaire

__New Patient __Reactivate __ New Episode __Aggravation __Other

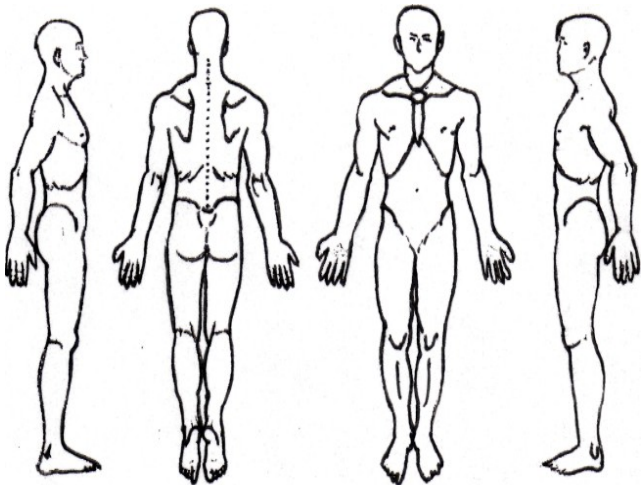
Patient Name_____ Date_____

CHIEF COMPLAINT

Read All Instructions! Complete Front and Back of Page!

• Mark the figures below with the symbols describing your pain sensation. Use the appropriate symbols. If there is more than one area o f complaint, number them according to severity. • Please rate the pain on a scale of 0 to 10 next to each area, with 0 being NO pain and 10 being INTOLERABLE pain.

+++ Burning
(((Aching Pain
>>> Pins & Needles
000 Numbness
:::: Sharp Pain



•Describe Your Symptoms: _____

_____

_____

_____

•When Did Your Symptoms Start? _____

_____

•How Did Your Symptoms Begin? _____

_____

•How Are Your Symptoms Changing?

•How Often Do You Experience Your Symptoms?

__ Constantly (76-100% of the day)
__ Frequently (51-75% of the day)
__ Occasionally (26-50% of the day)
__ Intermittently (0-25% of the day)

•What Makes Your Symptoms Worse? _____

•What Makes Your Symptoms Better?_____

•When are your Symptoms:

Better? __AM __Mid-day __PM
Worse? __AM __Mid-day __PM

•Who have you seen for your <u>current</u> symptoms?

__No One __ Physical Therapist __ Medical Doctor __ Chiropractor __ Other_____

a. What treatment did you receive? _____
b. What was your perceived outcome?_____
c. What tests were used for your symptoms and when?
__ X-Rays Date:_____ __MRI Date:_____ __ CT Scan Date:_____ __Other_____ Date:_____

•Have you had the same/similar symptoms in the past? __Yes __No **How many times?** __ 0-3 __ 4+

If Yes, who did you receive treatment from and what?_____