

Patient Name _____ Today's Date _____

Date of last exam: _____

Have you moved since your last exam? NO YES Has your insurance, or phone number changed? NO YES

Have you had any falls, injuries, or new symptoms since your last exam? YES NO

Have you been diagnosed with any new conditions since your last exam? (i.e. diabetes, high BP, etc.)?

NO YES

Have you started taking any new vitamins, supplements or OTC/Prescribed medications since last exam?

NO YES (name, dosage, frequency) _____

Have you had any NEW loss of control of or inability to evacuate bowels/bladder since last exam?

NO YES (please circle) BOWELS BLADDER

Have you developed any unexplained fevers, nausea, vomiting, weight loss, or vision changes since last exam?

NO YES (please circle) FEVER NAUSEA VOMITING WEIGHT LOSS VISION CHANGES

Have you seen any other Health Care Professionals for any of symptoms we are treating? NO YES

If YES: Why _____ Who: _____ When: _____

1. CHIEF COMPLAINT _____

Are you still having this? NO YES If NO, when did you last experience it? _____

If YES, has it gotten: BETTER WORSE NO CHANGE

How? LESS FREQUENCY MORE FREQUENCY LESS SEVERITY MORE SEVERITY

OTHER _____

Provocative/Palliative

What makes it worse? REST · SITTING · STANDING · WALKING · STRETCHES · ICE · HEAT · MEDS · ADJUST

OTHER _____

What makes it better? REST · SITTING · STANDING · WALKING · STRETCHES · ICE · HEAT · MEDS · ADJUST

OTHER _____

What time of day is it worst? MORNING AFTERNOON NIGHT SLEEP VARIES (based on activity)

OTHER _____

Quality

Describe your symptoms: sharp & stabbing / achy & dull / stinging / burning / throbbing / tingling / numbness /

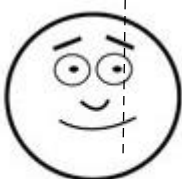
If radiating (what path does it follow?) _____

Rate/Severity (Use faces below as reference to answer questions)



0

No Symptoms



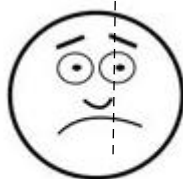
1-2

Have Symptoms
but can ignore them



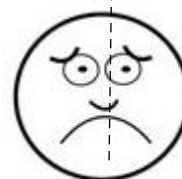
3-4

Makes some tasks
harder, can still do them



5-6

Notice Symptoms
interferes w/concentration



7-8

Interferes w/basic needs
(shower, clothes, walk, etc.)



9-10

Unable to do most things
due to symptoms

Using the above chart, can you rate your symptoms at this very moment? (circle one)

MILD: 0 - 1 - 2/10 · MODERATE: 3 - 4/10 · SEVERE: 5 - 6/10 · VERY SEVERE: 7 - 8 - 9 - 10/10

Since your last exam, what is symptom level at it's worst? (circle one)

MILD: 0 - 1 - 2/10 · MODERATE: 3 - 4/10 · SEVERE: 5 - 6/10 · VERY SEVERE: 7 - 8 - 9 - 10/10

Does pain interfere with daily activities? NO · YES (what activities, i.e. work / hobby / family / household chores):

Timing

How often do you feel your symptoms? 1-3x/day 1-3x/week 1-3x/month 1-3x/year NEVER GOES AWAY

OTHER _____

How long each episode last? ___SECS · ___MIN · ___HOURS · ___DAYS · ___WEEKS · ___MONTHS

2. COMPLAINT

Are you still having this? NO YES If NO, when did you last experience it? _____

If YES, has it gotten: BETTER WORSE NO CHANGE

How? LESS FREQUENCY MORE FREQUENCY LESS SEVERITY MORE SEVERITY

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Quality

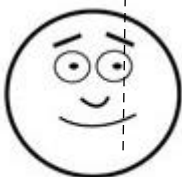
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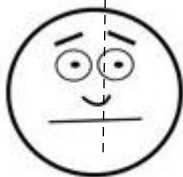
0

No Symptoms



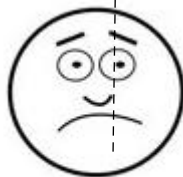
1-2

Have Symptoms
but can ignore them



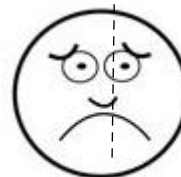
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Makes some tasks
harder, can still do them



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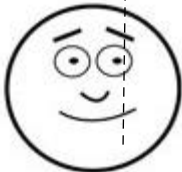
(#3 cont'd)

Rate/Severity (Use faces below as reference to answer questions)



0

No Symptoms



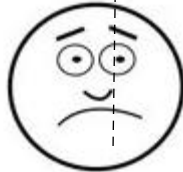
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Have Symptoms but can ignore them



3-4

Makes some tasks harder, can still do them



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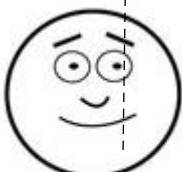
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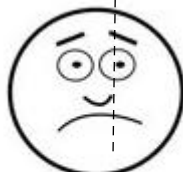
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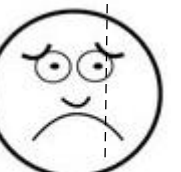
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(#4 cont'd)

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OTHER _____

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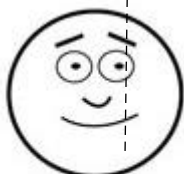
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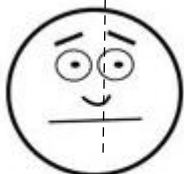
0

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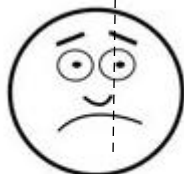
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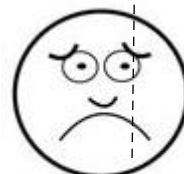
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OTHER _____

How long each episode last? ___SECS · ___MIN · ___HOURS · ___DAYS · ___WEEKS · ___MONTHS

Staff only:

NOTES: _____

Weight	
Height	
Blood Pressure	
Temperature	
Pulse	
pO ₂	