

HISTORY FORM

Date of Visit: _____ Acct. #: _____ SSN: _____ DOB: _____

Name: _____ Referring Physician: _____

Age _____

Sex: _____ Family Physician: _____

Parent or Guardian (if minor): _____

HISTORY OF PRESENT ILLNESS

Chief Complaint/Why are you here today: _____

Date of Injury or Symptoms: _____

How did injury/symptoms occur? _____

Have you received treatment for this injury/illness? Yes No _____

Location (where is the pain?) Right Left _____

Radiation (which extremity does pain radiate to?) _____

Quality (sharp, dull, stabbing): _____

Duration (how long have you had pain?) ____Days ____Weeks ____Months ____Years

Timing (when does pain occur? How long does it last?) _____

Context (what makes it worse?) _____

Modifying factors (what makes it better?) _____

Associated signs and symptoms (swelling, redness, fever, etc.) _____

Caused by accident? Yes No Are Attorneys involved? Yes No

Is this work related? Yes No Was it reported? Yes No

Discomfort Severity: 0 1 2 3 4 5 6 7 8 9 10 (highest)