Current Complaint

Name: _____ **Chart #:** _____ **Today's Date:** _____ **Doctor:** _____

What is your current complaint? (why are you seeking treatment?) _____

_____

_____

_____

How severe is this problem?
- ☐ Mild
- ☐ Mild to Moderate
- ☐ Moderate
- ☐ Moderately Severe
- ☐ Severe

How Frequently?
- ☐ Constant
- ☐ Occasional
- ☐ Intermittent
- ☐ Frequent

On a 1-10 scale, how would you rate your pain?
(10=most painful, 1=least painful)

☐ 1	☐ 5	☐ 9
☐ 2	☐ 6	☐ 10
☐ 3	☐ 7	
☐ 4	☐ 8	

Improvement (%)

☐ 10%	☐ 60%
☐ 20%	☐ 70%
☐ 30%	☐ 80%
☐ 40%	☐ 90%
☐ 50%	☐ 100%

When was the onset of this problem?

☐ gradual	☐ about a day ago	☐ several months ago
☐ sudden	☐ several days ago	☐ about a year ago
☐ insidious	☐ about a week ago	☐ several years ago
	☐ several weeks ago	
	☐ about a month ago	

Select each choice that applies to you

Movement
- ☐ Cramps ☐ Stiffness
- ☐ Inflexibility
- ☐ Restricted Movement
- ☐ Spasm

Sensation
- ☐ Crawling ☐ Prickly
- ☐ Dead ☐ Tingling
- ☐ Numb
- ☐ Pins and needles

Select the type of pain that best describes your complaint

☐ Achy	☐ Numb ache	☐ Shooting
☐ Burning	☐ Pounding	☐ Stabbing
☐ Dull	☐ Pulsating	☐ Stinging
☐ Excruciating	☐ Sharp	☐ Throbbing

Please indicate everything that makes you feel better

☐ usually better in the morning ☐ usually better during the day ☐ usually better at night

_____

_____

_____

_____

Please indicate everything that makes you feel worse or aggravates your condition

☐ usually worse in the morning ☐ usually worse during the day ☐ usually worse at night

_____

_____

_____

_____

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: _____