

NEW PATIENT & NEW COMPLAINT HISTORY FORM

Patient Name: _____ Date of Birth: _____ Date: _____

Who referred you to our office? _____

What are we seeing you for today? _____

Side: LEFT RIGHT BOTH

When did your symptoms begin (date)? _____ Did you have an injury: Yes No

Why do you think your symptoms started? _____

On a scale of 0-10 (0 is no pain, 10 is the worst) how would you rate your pain?

(Circle) 0 1 2 3 4 5 6 7 8 9 10

Pain frequency: Constant Intermittent Occasional Rare

Since your problem started, it is: Getting better Getting worse Unchanged

Quality of pain: Aching Burning Dull Sharp Throbbing Other: _____

What makes your symptoms worse? Bending Climbing Stairs Descending stairs Sitting
Standing Lifting Movement Pushing Walking Other: _____

What makes your symptoms better? Brace/Splint Elevation Exercise Heat Ice Injection
Massage OTC/Rx Meds Therapy Rest Stretching Other: _____

Associated symptoms: Bruising Crepitus Decreased mobility Instability Limping
Locking Numbness Popping Spasms Swelling Tingling Weakness

Nocturnal awakening

Height: ____ / ____ Weight: _____