

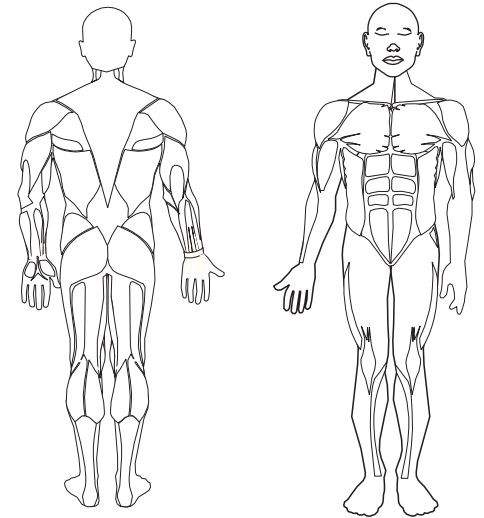
## History of Present Illness

Patient Name \_\_\_\_\_ # \_\_\_\_\_ Date \_\_\_\_\_

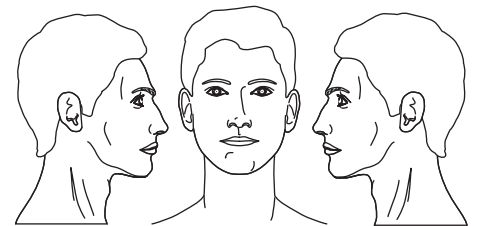
Chief Complaint \_\_\_\_\_

RIGHT SIDE	Pain	Numbness	Tingling	Stiffness	Soreness	Swelling	Weakness	Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Stinging	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved		
	Head																									
Neck																										
Upr Back																										
Mid Back																										
Low Back																										
Shoulder																										
Elbow																										
Wrist																										
Hand																										
Hip																										
Knee																										
Ankle																										
Foot																										

Mark Pain Location



LEFT SIDE	Pain	Numbness	Tingling	Stiffness	Soreness	Swelling	Weakness	Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Stinging	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved		
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Symptom Start Date \_\_\_\_\_ How Did It Start:  Gradual  Sudden (explain) \_\_\_\_\_

Are You Getting?  Better  Worse  Same When Is It Worse?  Morning  Afternoon  Evening  Night

If Your Complaint Includes Pain, Is It Aggravated By?

Coughing  Sneezing  Reaching  Lifting  Bending  Sitting  Standing  Walking  Straining At Stool  
 Neck Movement  Other \_\_\_\_\_

If Your Complaint Includes Pain, Is It Relieved By?

Nothing  Rest  Ice  Heat  Stretching  Exercise  Sitting  Standing  Other \_\_\_\_\_

Have You Noticed A Change In?  Bowel Function  Bladder Function  Sexual Function  No

Has This Condition Existed In The Past?  Yes  No

Since Your Last Exam, Have You Had Any:  Accidents  Illnesses  Exam or Treatments Elsewhere  No  
 Other \_\_\_\_\_