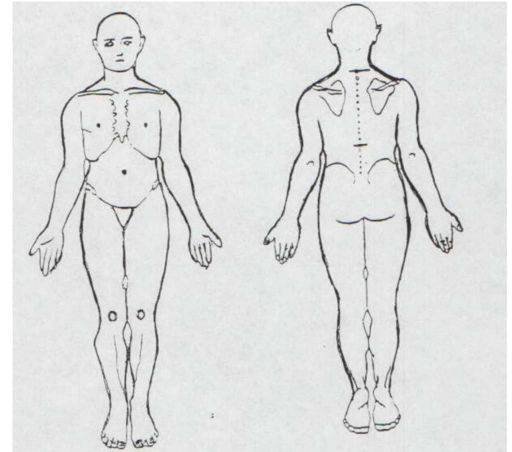
Physical Dimensions Integrative Health Group
Chief Complaint Form

(most important form, please be complete)

__New Patient __Reactivate __ New Episode __Aggravation __Other

+++ Burning
(((Aching Pain
>>> Pins & Needles
000 Numbness
:::: Sharp Pain

1. **Date _______________**
2. **Chief complaint (please put primary 2 concerns only and also mark diagram):**
   1.____
   2.____ _
3. **What was cause of injury (How did it happen)?**
   1.____
   2.____
4. **When approximately did this issue begin?**
   1.________________________ 2. _________________________



5. **Who have you seen for your <u>current</u> symptoms?**
   __No One __ Physical Therapist __ Medical Doctor __ Chiropractor __ Other______________________

   a. What treatment(s) did you receive (core, injections, meds, braces, etc)____
   ____

   b.What was outcome (reduce symptoms, temporary, etc)? ____
   ____

6. **Frequency of Symptoms:** 1. ___Constant (76-100%) ___Frequent(51-75%) ___Occasional(26-50%)___Intermittent(<25%)
   2.___Constant (76-100%) ___Frequent(51-75%) ___Occasional(26-50%)___Intermittent(<25%)
7. **What make condition worse (positions, activity, etc)?**
   1.____ 2.____
8. **What makes condition better (meds, ice/heat, positions, past PT, etc)?**
   1.____ 2.____
9. **Previous episodes/significant trauma in same area?**
   1.____2.____
10. **Tests Performed for Condition: Test, date, result**
    (MRI, Xray, CT, Ultrasound and what results)
    a.____
    b.____
    c.____
    d.____
11. **On a scale of 1-10 with 10 being unbearable, rate your current level of complaint:**

	(Barely Noticeable)			(moderate nag)			(unbearable)			
Condition #1	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Condition #2	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

12. **Any changes in medical or surgical history since last visit?**
    ____

Any urgency involved in your issue (work trip, race, loss of sleep, etc)?
____
____
____

ACTIVITIES OF DAILY LIVING

Indicate Your Ability to Perform the Following Activities. Please Use These Codes.

U-Unable **L**-Limited **P**-Painful **D**-Difficult **N**-Normal **H**-Haven't Tried

1.___Lying on Back
2.___Lying on Side
3.___Lying Flat on Stomach
4.___Turning Over in Bed
5.___Getting In/Out of Car
6.___Reaching
7.___Gripping
8.___Climbing
9.___Pulling
10.___Dressing Self
11.___Sexual Activity
12.___Sleeping
13.___Pushing
14.___Kneeling
15.___Stooping
16.___Sitting (work,home)
17.___Bending Forward
18.___Walking Short Distances
19.___Bending to Brush Teeth
20.___Standing 1+ hours
21.___Balancing
22.___Cough/Sneeze/Grunt
How?_____________
Where?_____________

23.___Other 24.___Other 25.___Other

FILL OUT NEXT SECTIONS AS THEY APPLY TO YOU

HEADACHE

Yes No

Do You Experience:

___ ___ Nausea, Vomiting, or Visual Disturbances?
___ ___ Radiation (travel) of Pain from Neck?
___ ___ Pain/Clicking in Jaw?
___ ___ Abnormal Blood Pressure?
___ ___ Family History of Headaches?

Frequency of Headaches:________________

LUMBOSACRAL SPINE (Lowback)

Yes No

___ ___ Feeling of Ripping or Tearing?
Where?____________________________
___ ___ Does the Pain Radiate (travel) to the Abdomen?
___ ___ Does the Pain Radiate (travel) into the Leg?
___ ___ Impairment of Bowel or Bladder Function?
Explain:_____________________________

CERVICAL SPINE (Neck)

Yes No

___ ___ Neck Injury that Affects Hearing, Vision, Balance or Causes Ringing in Ears?
___ ___ Do You Hear Grating Sounds?
___ ___ Is Your Swallowing Affected?

Yes No

___ ___ Difficulty Turning Head? __Right __Left
___ ___ Pain/Pressure Behind Eyes?
___ ___ Feeling of Ripping/Tearing
Where?______________________________

During the past <u>4 Weeks</u>, how much has the pain interfered with your work (including housework, job, etc)?

__Not at all __ Little bit __ Moderately __Quite a bit __ Extremely

During the past <u>4 Weeks</u>, how much has the pain interfered with your Social Life?

__Not at all __ Little bit __ Moderately __Quite a bit __ Extremely