

HISTORY OF ADDITIONAL COMPLAINT

Intern: _____ Doc #: _____ Patient: _____ File #: _____ Date: _____

Please describe the symptom(s) of your complaint: _____

ONSET

When did you start to have the symptom(s)? _____

How did the symptoms start? Can you identify a reason for the symptom(s)? _____

If you have had these symptoms before, please describe: _____

PROVOCATIVE

What makes the symptoms worse (check all that apply)?

- Sitting Standing Moving Bending Forward Driving Coughing Sneezing Bearing Down
 Other(s): _____

PALLATIVE

What makes it feel better?

QUALITY

Which best describes the quality of the symptoms? Please check all that apply or describe:

- Dull Ache Sharp Deep Superficial Burning Numbness Shooting Tingling Stiff Tight

Other: _____

RADIATION

If the symptoms radiate, please describe where: _____

SEVERITY

On a scale of 1 – 10, 10 being the worst pain, what is the level of pain:

____ right now ____ at best ____ at worst ____ most of the time

TIMING

How many days a week do you experience your symptom(s)? _____

On average, how long do you experience your symptom(s) in the course of a 16 hour day?

- Infrequent Occasionally Intermittently Frequently Constantly
 (2 hrs of the day) (4 hrs of the day) (8 hrs of the day) (12 hrs of the day) (16 hrs of the day)

Does the **pain** wake you up? Yes No - If yes, does it keep you from sleeping? Yes No

Have you seen any other health care providers for this complaint? Yes No - If yes, please list they type of provider:

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