Monte H. Greenawalt
LIFE WEST
HEALTH CENTER
Chiropractic | Health | Wellness

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:

_____

Intern Notes:

_____

_____

_____

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