



**VITAL SIGNS**

Pulse \_\_\_\_\_ Respirations \_\_\_\_\_ Blood Pressure \_\_\_\_\_ / \_\_\_\_\_ Height \_\_\_\_\_  
 Weight \_\_\_\_\_

**HISTORY OF PRESENT ILLNESS**

**What problem(s) brought you into the Doctor today? Check all that apply, write a R, L, or B (for right, left or both) beside the body part if there is more than one area**

- Neck       Back       Shoulder       Arm       Shoulder       Elbow       Hand  
 Hip       Knee       Ankle       Foot      Other \_\_\_\_\_  
 Right       Left       Both       Right worse than left       Left worse than right       Both same

**When** did it start? \_\_\_\_ / \_\_\_\_ / \_\_\_\_       Not sure      \_\_\_\_\_       Mos       Wks       Days *Before today*

Did the problem **start** with a injury or accident?       Yes       No      Did it occur at **work**?       Yes       No

Describe the pain       Sharp       Other       Intermittent       Other  
 Dull      \_\_\_\_\_       Constant      \_\_\_\_\_  
*Check all that apply*       Burning      \_\_\_\_\_       One area      \_\_\_\_\_  
 Multiple areas

How **severe** is the pain on a scale of 1 to 10 with 10 being the worst pain imaginable?

*Circle one*      0      1      2      3      4      5      6      7      8      9      10

What makes the problem **worse**? \_\_\_\_\_

What makes the a problem **better**? \_\_\_\_\_

Does the problem/pain occur at any particular time of the day?       Yes       No       Not sure

If so when does it occur? (check all that apply)       Morning       During day       After work  
 At night       All the time      Other \_\_\_\_\_

Have you been seen or **treated** for this problem before?       Yes       No

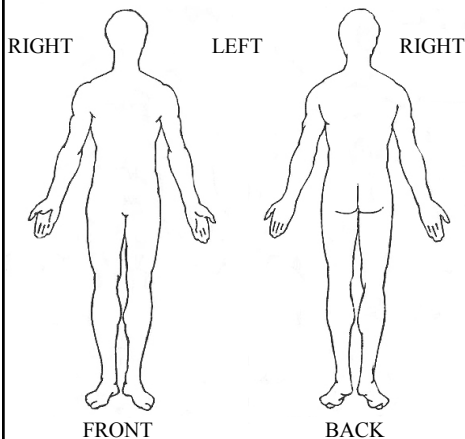
If so by whom? \_\_\_\_\_

What treatments have you had?       None       Medicine       Physical Therapy       Surgery  
 Other \_\_\_\_\_

Did any of these treatments help?       Yes       Yes, but it came back       Partially  
 No

Have you had anything like this in the past?       Yes       No       Not sure

*Please place an X on the areas where you feel pain on the picture below.*



**NOTES**      *Staff use only*

Reviewed by	
Initials	Date