Arlington Family Chiropractic Clinic

Chief Complaint
(History of Present Illness)

Patient Name: ____ Case: _____________ Date: ________________

Where is your pain/discomfort?:____

Body area(s) involved: □ Neck □ mid-low back, pelvis □ Upper extremity □ Lower Extremity

Condition: □ New □ Recurring □ Exacerbation □ Chronic

Mechanism of Onset:

□ New Auto Accident (ask for accident history form)
□ Gardening/yard work □ slip or fall □ Lifting □ Overexertion □ Repetitive motion
□ slept wrong □ new sports injury □ old sports injury □ old auto accident
□ Other: ________________________ □Unknown

Symptoms: □ Pain □ Numbness □ Stiffness □ Weakness

Location: Left/Right/Bilateral ____

Quality: □ Burning □ Diffuse □ Dull/Aching □ Localized □ Sharp □ Shooting □ Stabbing
□ Throbbing □ Tightness □ Tingling □ Radiating □ Other __________________________

Level of discomfort (pain) due to symptoms (when resting)

0 1 2 3 4 5 6 7 8 9 10

Level of discomfort (pain) due to symptoms (when active)

0 1 2 3 4 5 6 7 8 9 10

Duration: Symptom(s) started: _________ Symptom(s) worsened: ________ Symptom(s) last occurred:______

Injury occurred: __________ Accident occurred: ___________

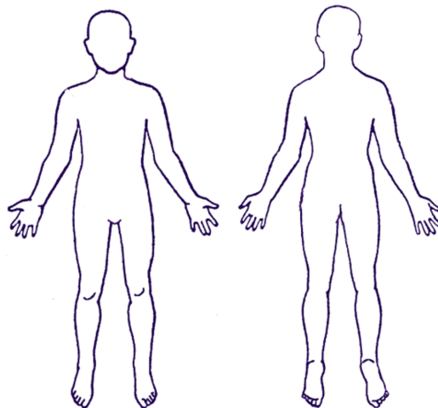
Timing: How often are symptoms present: □ Constantly □ Frequently □ Intermittently □ Occasionally

Timing: Worse in the: □ Morning □ Afternoon □ Night □ With Activity □ Constant □ Intermittent

Use the letters below to indicate the type and the location of your sensations right now.

A = Ache B = Burning N = Numbness

P = Pins & Needles S = Stabbing O = Other



History of Present Illness continued

Associated signs and symptoms: □ blurred vision □ depression □ dizziness □ headaches (see below)

□ irritability/mood swing □ localized tingling □ nausea □ ringing in the ears □ stiffness

□ Aches □ Cold Limb □ Bruising □ Fatigue □ Fever □ Heartburn □ Runny nose

□ Muscle Spasm □ Nausea □ Numbness □ Pale bluish skin □ Panic □ Pins & Needles

□ Sweating □ Swelling □ Vomiting □ Weakness

Headaches: Location: □ Back of head □ Frontal □ at the temples □ Side of head □ Sinus region
Quality: □ Dull □ Sharp □ Throbbing □ Stabbing □ Aura □ no Aura
Type: □ Hat band □ Cluster □ Migraine □ Tension
Frequency: □ Daily □ Weekly □ Monthly □ Occasionally

Modifying factors: Symptoms better with: □ Activity □ Bending □ Cold □ Heat □ Massage □ Movement

□ OTC meds □ RX meds □ Rest □ Stretching □ Sitting □ Standing □ Twisting □ Walking

□ Nothing helps

Condition's effect on Job performance: What type of work do you do?___________________________________

□ Mild painful (can do) □ Mod painful (limits ability) □ Mod/Sev (limited duty) □ Sev (can't do limited duty)

Daily Activities: Effects of current condition on performance
Place and X in the blocks that best describe your current limitations due to your condition

ACTIVITY	No effect	Mild—can do but causes extra pain	Moderate—50% limited due to pain	Mod-Sev—75% limited due to pain	Severe—76% to 100% limited due to pain
Bending					
Social Life					
Sit to Stand					
Climb Stairs					
Driving					
Computer Use					
Household chores					
Kneeling					
Lifting					
Personal Care (bathing & dressing)					
Sitting					
Sleep					
Standing					
Walking					
Yard Work					
Other: ____________					

Medical/Family History: S = self M = mother F = father

Please indicate which PAST conditions have been experienced prior to present complaint by marking appropriate boxes.

S	M	F		S	M	F	
☐	☐	☐	Heart Disease	☐	☐	☐	Diabetes
☐	☐	☐	Arthritis	☐	☐	☐	High Blood Pressure
☐	☐	☐	Cancer	☐	☐	☐	Thyroid Disease
☐	☐	☐	Chest Pain	☐	☐	☐	TIA/Stroke

Surgical History:

1.____ Date: _____________________

2.____ Date: ______________________

3.____ Date:______________________

4.____ Date:______________________

Are you allergic to any medications? Y/N If yes, what kind?_________________________________

____

Social History:

Do you smoke? Y/N If yes, how much?________________________

Do you drink alcohol? Y/N If yes, how often and how much?_____________________________

Do you use illicit drugs? Y/N, If yes, please describe?_____________________________________

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

____ _______________________

Signature of Patient (or Guardian)   Date