

Use this form to report symptoms for more than one Chief Complaint

Problem # 2	Problem # 3	Problem # 4
Area _____ <input type="checkbox"/> R <input type="checkbox"/> L	Area _____ <input type="checkbox"/> R <input type="checkbox"/> L	Area _____ <input type="checkbox"/> R <input type="checkbox"/> L
1.) How long ago did this start? (Add a #) ___ Days ___ Weeks ___ Months	1.) How long ago did this start? (Add a #) ___ Days ___ Weeks ___ Months	1.) How long ago did this start? (Add a #) ___ Days ___ Weeks ___ Months
2.) How did it start? <input type="checkbox"/> Same as problem #1 <input type="checkbox"/> Other: _____	2.) How did it start? <input type="checkbox"/> Same as problem #1 <input type="checkbox"/> Other: _____	2.) How did it start? <input type="checkbox"/> Same as problem #1 <input type="checkbox"/> Other: _____
3.) Severity of pain out of 10 (circle) 0 1 2 3 4 5 6 7 8 9 10	3.) Severity of pain out of 10 (circle) 0 1 2 3 4 5 6 7 8 9 10	3.) Severity of pain out of 10 (circle) 0 1 2 3 4 5 6 7 8 9 10
4.) What is the <u>quality</u> of the pain? <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing <input type="checkbox"/> Aching <input type="checkbox"/> Burning	4.) What is the <u>quality</u> of the pain? <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing <input type="checkbox"/> Aching <input type="checkbox"/> Burning	4.) What is the <u>quality</u> of the pain? <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing <input type="checkbox"/> Aching <input type="checkbox"/> Burning
5.) Choose one: The pain is <input type="checkbox"/> constant <input type="checkbox"/> comes and goes	5.) Choose one: The pain is <input type="checkbox"/> constant <input type="checkbox"/> comes and goes	5.) Choose one: The pain is <input type="checkbox"/> constant <input type="checkbox"/> comes and goes
6.) Does this pain wake you from sleep? <input type="checkbox"/> Yes <input type="checkbox"/> No	6.) Does this pain wake you from sleep? <input type="checkbox"/> Yes <input type="checkbox"/> No	6.) Does this pain wake you from sleep? <input type="checkbox"/> Yes <input type="checkbox"/> No
7.) In this area, do you have ? <input type="checkbox"/> Swelling <input type="checkbox"/> Bruise <input type="checkbox"/> <u>Numbness</u> <input type="checkbox"/> <u>Tingling</u> <input type="checkbox"/> Weakness <input type="checkbox"/> loss of control of bowel/ bladder	7.) In this area, do you have ? <input type="checkbox"/> Swelling <input type="checkbox"/> Bruise <input type="checkbox"/> <u>Numbness</u> <input type="checkbox"/> <u>Tingling</u> <input type="checkbox"/> Weakness <input type="checkbox"/> loss of control of bowel/ bladder	7.) In this area, do you have ? <input type="checkbox"/> Swelling <input type="checkbox"/> Bruise <input type="checkbox"/> <u>Numbness</u> <input type="checkbox"/> <u>Tingling</u> <input type="checkbox"/> Weakness <input type="checkbox"/> loss of control of bowel/ bladder
8.) What makes your symptoms <u>worse</u> ? <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Lifting <input type="checkbox"/> Exercise <input type="checkbox"/> Twisting <input type="checkbox"/> Lying <input type="checkbox"/> Bending <input type="checkbox"/> Squatting <input type="checkbox"/> Kneeling <input type="checkbox"/> Stairs <input type="checkbox"/> Sitting <input type="checkbox"/> Coughing <input type="checkbox"/> Sneezing	8.) What makes your symptoms <u>worse</u> ? <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Lifting <input type="checkbox"/> Exercise <input type="checkbox"/> Twisting <input type="checkbox"/> Lying <input type="checkbox"/> Bending <input type="checkbox"/> Squatting <input type="checkbox"/> Kneeling <input type="checkbox"/> Stairs <input type="checkbox"/> Sitting <input type="checkbox"/> Coughing <input type="checkbox"/> Sneezing	8.) What makes your symptoms <u>worse</u> ? <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Lifting <input type="checkbox"/> Exercise <input type="checkbox"/> Twisting <input type="checkbox"/> Lying <input type="checkbox"/> Bending <input type="checkbox"/> Squatting <input type="checkbox"/> Kneeling <input type="checkbox"/> Stairs <input type="checkbox"/> Sitting <input type="checkbox"/> Coughing <input type="checkbox"/> Sneezing
9.) Have you had any of these ? Injection <input type="checkbox"/> Y <input type="checkbox"/> N Brace <input type="checkbox"/> Y <input type="checkbox"/> N Therapy <input type="checkbox"/> Y <input type="checkbox"/> N Cane/Crutch <input type="checkbox"/> Y <input type="checkbox"/> N	9.) Have you had any of these ? Injection <input type="checkbox"/> Y <input type="checkbox"/> N Brace <input type="checkbox"/> Y <input type="checkbox"/> N Therapy <input type="checkbox"/> Y <input type="checkbox"/> N Cane/Crutch <input type="checkbox"/> Y <input type="checkbox"/> N	9.) Have you had any of these ? Injection <input type="checkbox"/> Y <input type="checkbox"/> N Brace <input type="checkbox"/> Y <input type="checkbox"/> N Therapy <input type="checkbox"/> Y <input type="checkbox"/> N Cane/Crutch <input type="checkbox"/> Y <input type="checkbox"/> N
10.) Have you had surgery for this problem? <input type="checkbox"/> Y <input type="checkbox"/> N Procedure #1 _____ Surgeon _____ Year _____ City _____	10.) Have you had surgery for this problem? <input type="checkbox"/> Y <input type="checkbox"/> N Procedure #1 _____ Surgeon _____ Year _____ City _____	10.) Have you had surgery for this problem? <input type="checkbox"/> Y <input type="checkbox"/> N Procedure #1 _____ Surgeon _____ Year _____ City _____