Patient Name: _____ Date: _____ 4.

CHIEF COMPLAINT: _____ Cause: _____

Date of current onset: _____Have you had this pain before? Y N If yes, when? _____
Degree of Discomfort: 1-10 (with 10 being the worst)_____

Description of Discomfort: (Sharp, Dull, Burning, Aching, Stabbing, Numb, Pins and Needles): _____

Please circle: constant / intermittent Please circle: day / night

What activities or positions aggravate your condition?_____
What makes the pain less intense? _____

SECONDARY COMPLAINT: _____Cause:_____

Date of current onset: _____ Have you had this pain before? Y N If yes, when? _____
Degree of Discomfort: 1-10 (with 10 being the worst) _____

Description of Discomfort: (Sharp, Dull, Burning, Aching, Stabbing, Numb, Pins and Needles): _____

Please circle: constant / intermittent Please circle: day/ night

What activities or positions aggravate your condition? _____
What makes the pain less intense? _____

ADDITIONAL COMPLAINT: _____ Cause: _____

Date of current onset: _____ Have you had this pain before? Y N If yes, when? _____
Degree of Discomfort: 1-10 (with 10 being the worst) _____

Description of Discomfort: (Sharp, Dull, Burning, Aching, Stabbing, Numb, Pins and Needles: _____

Please circle: constant/ intermittent Please circle: day/night

What activities or positions aggravate your condition? _____
What makes the pain less intense? _____