

# CHIEF COMPLAINT FORM

NAME \_\_\_\_\_ DATE \_\_\_\_\_

WHAT IS YOUR **MAIN** COMPLAINT TODAY?

HOW LONG HAVE YOU HAD THIS CONDITION? \_\_\_\_\_

HOW DID THIS CONDITION BEGIN? \_\_\_\_\_

IS THERE ANYTHING THAT WILL MAKE THIS CONDITION BETTER? \_\_\_\_\_

IS THERE ANYTHING THAT WILL MAKE THIS CONDITION WORSE? \_\_\_\_\_

IS THERE ANY PART OF THE DAY THAT YOUR CONDITION IS BETTER? \_\_\_\_\_

IS THERE ANY PART OF THE DAY THAT YOUR CONDITION IS WORSE? \_\_\_\_\_

HAS YOUR CONDITION BEEN CONSTANT OR DOES IT COME AND GO? \_\_\_\_\_

HAVE YOU SEEN ANY OTHER HEALTH CARE PRACTITIONER FOR THIS CONDITION? IF SO, WHO AND WHEN?

IF THERE IS PAIN INVOLVED, ON A SCALE OF 1 – 10 (10 BEING THE WORST POSSIBLE PAIN YOU CAN THINK OF), HOW WOULD YOU RATE THIS PAIN:

**RIGHT NOW?** \_\_\_\_\_/10    **THE WORST POINT?** \_\_\_\_\_/10    **THE BEST POINT?** \_\_\_\_\_/10

IS THIS PAIN/SENSATION: (PLEASE CIRCLE)

**SHARP   STABBING   DULL   ACHY   THROBBING   TINGLING   STIFF   BURNING   NUMB**

PLEASE INDICATE THE AREA OF COMPLAINT (IF APPLICABLE):

