Chief Complaint – History of Present Illness

BETTER LIFE
WELLNESS CENTER

Patient Name: _____

Chief Complaint: _____

Description of Onset: _____

Circle one: **New** **Recurrence (Acute)** **Exacerbation (Acute)** **Chronic**

QUALITY ❑ Burning ❑ Diffuse ❑ Dull/Aching ❑ Localized
❑ Radiating ❑ Sharp ❑ Shooting ❑ Stabbing ❑ Throbbing
❑ Tightness ❑ Tingling ❑ Other _____

Level of Impairment Due to Symptoms

Mild *Moderate* *Severe*

0 1 2 3 4 5 6 7 8 9 10

Pain Frequency (%)

Occasional *Intermittent* *Frequent* *Constant*

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

DURATION Started: _____ Last Occurred: _____
Last Episode: _____ Resolved Previous Visit: _____
Worsened: _____ Injury Occured: _____
Accident Occured: _____

TIMING *Worse:* ❑ Morning ❑ Afternoon ❑ Night
❑ With Activity; ❑ Constant ❑ Intermittent

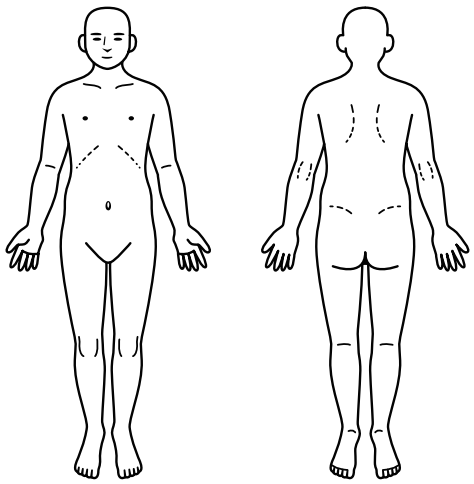
ASSOCIATED SYMPTOMS ❑ Blurred Vision ❑ Dizziness
❑ Nausea ❑ Ringing in Ears ❑ Irritability ❑ Depression
❑ Sleep Distubance ❑ Localized Tingling ❑ Stiffness

REFERRAL PAIN/NUMBNESS _____

WEAKNESS _____

LABEL THE DIAGRAM

A=Ache B=Burning N=Numbness



HEADACHES

Location

❑ Occipital ❑ Frontal ❑ Parietal
❑ Temporal (Right / Left) ❑ Sinus

Quality

❑ Dull ❑ Sharp ❑ Throbbing
❑ Stabbing ❑ Aura ❑ No Aura

Types

❑ Hat Band ❑ Cluster
❑ Migraine ❑ Tension

Other: (frequency/duration/time of day)

_____

❑ Denies Sudden/Severe Onset

MODIFYING FACTORS *Symptoms are better with:* ❑ Activity ❑ Bending ❑ Applying Cold ❑ Applying Heat ❑ Massage ❑ Movement ❑ OTC Medication ❑ RX Medication ❑ Rest ❑ Stretching ❑ Sitting ❑ Standing ❑ Twisting ❑ Walking

ACTIVITIES OF DAILY LIVING *Check any daily activities that are affected by current condition*

	Mild *(Painful, Can Do)*	**Moderate** *(Limited)*	**Severe** *(Unable To Perform)*
Bending			
Breathing			
Changing Positions			
Church Activities			
Climbing Stairs			
Computer Use			
Concentration			
Cooking			
Cycling			
Driving			
Exercising			
Gardening			
Golf			
Hiking			
Household Chores			
Hunting			
Kneeling			
Lifting			
Pickle Ball			
Self Care			
Sleeping			
Static Sitting			
Static Standing			
Turning Head			
Walking			
Yard Work			

EMPLOYMENT _____

Condition's Effect On Job Performance:

Mild (Painful, Can Do) Moderate (Limited) Severe (Unable To Work)

Review of Systems

Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

CONSTITUTIONAL ❑ *No Symptoms Apply*

❑ Chills ❑ Fever ❑ Night sweats
❑ Daytime drowsiness ❑ Fatigue
❑ Weight gain ❑ Weight loss

EYES/VISION ❑ *No Symptoms Apply*

❑ Blindness ❑ Blurred vision ❑ Glasses/Contacts
❑ Changes in vision ❑ Double vision ❑ Itching ❑ Tearing
❑ Photophobia ❑ Glaucoma ❑ Cataracts ❑ Eye pain

EARS, NOSE, & THROAT ❑ *No Symptoms Apply*

❑ Bleeding ❑ Ear drainage ❑ Hearing loss ❑ Ear pain ❑ Nosebleeds ❑ Sore throat ❑ Dentures
❑ Difficulty swallowing ❑ Fainting ❑ Hoarseness ❑ History of head injury ❑ Postnasal drip
❑ Tinnitus (ringing in ears) ❑ Rhinorrhea (runny nose) ❑ Discharge ❑ Frequent sore throats
❑ Lost of sense of smell ❑ Sinus infections ❑ Headaches ❑ Nasal congestion ❑ Snoring

CARDIOVASCULAR ❑ *No Symptoms Apply*

❑ Angina (hest pain or discomfort) ❑ High blood pressure
❑ Shortness of breath w/ exertion/exercise ❑ Chest pain
❑ Low blood pressure ❑ Swelling of legs ❑ Varicose veins
❑ Claudication (leg pain/ache) ❑ Ulcers ❑ Palpitations
❑ Orthopnea (difficulty breathing lying down) ❑ Heart murmur
❑ Paroxysmal nocturnal dyspnea (shortness of breath walking at night) ❑ Heart problems

GASTROINTESTINAL ❑ *No Symptoms Apply*

❑ Abdominal pain ❑ Diarrhea ❑ Indigestion ❑ Belching
❑ Abnormal stool caliber ❑ Abnormal stool color ❑ Jaundice
❑ Abnormal stool consistency ❑ Vomiting blood ❑ Vomiting
❑ Difficulty swallowing ❑ Black - tarry stools ❑ Heartburn
❑ Constipation ❑ Hemorrhoids ❑ Rectal bleeding ❑ Nausea

ENDOCRINE ❑ *No Symptoms Apply*

❑ Cold intolerance ❑ Excessive hunger ❑ Excessive thirst
❑ Goiter ❑ Unusual hair growth ❑ Diabetes ❑ Hair loss
❑ Voice changes ❑ Excessive appetite ❑ Heat intolerance

RESPIRATION ❑ *No Symptoms Apply*

❑ Asthma ❑ Coughing up blood
❑ Cough ❑ Shortness of breath
❑ Wheezing ❑ Sputum production

FEMALE ❑ *No Symptoms Apply*

❑ Cramps ❑ Irregular menstruation
❑ Pregnancy ❑ Birth control
❑ Hormone therapy ❑ Breast lump/pain
❑ Vaginal discharge ❑ Vaginal bleeding
❑ Urine retention ❑ Burning urination
❑ Frequent urination

MALE ❑ *No Symptoms Apply*

❑ Burning urination ❑ Urine retention
❑ Frequent urination
❑ Prostate problems
❑ Erectile dysfunction
❑ Hesitancy/dribbling

Review of Systems – Continued

ALLERGY ❑ *No Symptoms Apply*

❑ Itching ❑ Sneezing ❑ Rash
Nasal congestion; ❑ Acute ❑ Chronic
❑ Food intolerance ❑ Anaphalaxis

SKIN ❑ *No Symptoms Apply*

❑ Hair loss ❑ Hair growth ❑ Itching ❑ Hives ❑ Varicosities
❑ Changes in nail texture ❑ Changes in skin color ❑ Rash
❑ History of skin disorders ❑ Paresthesias ❑ Lesions/ulcers

NERVOUS SYSTEM ❑ *No Symptoms Apply*

❑ Dizziness ❑ Limb weakness ❑ Numbness ❑ Slurred speech ❑ Tremor ❑ Facial weakness
❑ Loss of consciousness ❑ Seizures ❑ Stress ❑ Headache ❑ Loss of memory ❑ Sleep disturbance
❑ Unsteadiness of gait/loss of balance ❑ Strokes

PSYCHOLOGIC ❑ *No Symptoms Apply*

❑ Anxiety ❑ Confusion ❑ Insomnia
❑ Anhedonia ❑ Convulsions ❑ Memory loss
❑ Behavioral change ❑ Depression ❑ Mood changes
❑ Bi-polar disorder ❑ Loss/change of appetite

HEMATOLOGIC ❑ *No Symptoms Apply*

❑ Anemia ❑ Bleeding
❑ Blood clotting ❑ Blood transfusion
❑ Bruising easily
❑ Fatigue ❑ Lymph node swelling

Personal Health History

SURGERIES *List all surgical procedures, **including the date of procedure***

❑ Spinal surgery: _____ ❑ Spinal fusion: _____ ❑ Joint replacement: _____
List Level *List Joint*
Rotator cuff; ❑ Left ❑ Right _____
Other _____
_____

INJURIES *Please list all injuries, **including the date of injury***

_____
_____
_____

CONTRIBUTORY *Add location/dates*

❑ Stroke: _____ ❑ Cancer: _____
❑ Osteoporosis: _____
❑ Scoliosis ❑ Steroid use ❑ Fibromyalgia
❑ Arthritis ❑ Depression ❑ Stress

CHILDHOOD ILLNESSES

_____
_____

ADULT ILLNESSES

_____
_____

CURRENT MEDICATIONS

*Please list any/all medications you are **currently** taking*

Medication	Dosage	For what condition?	For how long?

FAMILY HISTORY

Mark all that apply below - list any specific conditions past or present after has/had

General family	❑ Alive	❑ Deceased	❑ Normally developed	❑ No significant disease	❑ Has/had: _____
Father	❑ Alive	❑ Deceased	❑ Normally developed	❑ No significant disease	❑ Has/had: _____
Mother	❑ Alive	❑ Deceased	❑ Normally developed	❑ No significant disease	❑ Has/had: _____
Paternal grandfather	❑ Alive	❑ Deceased	❑ Normally developed	❑ No significant disease	❑ Has/had: _____
Paternal grandmother	❑ Alive	❑ Deceased	❑ Normally developed	❑ No significant disease	❑ Has/had: _____
Maternal grandfather	❑ Alive	❑ Deceased	❑ Normally developed	❑ No significant disease	❑ Has/had: _____
Maternal grandmother	❑ Alive	❑ Deceased	❑ Normally developed	❑ No significant disease	❑ Has/had: _____
Son(s)	❑ Alive	❑ Deceased	❑ Normally developed	❑ No significant disease	❑ Has/had: _____
Daughter(s)	❑ Alive	❑ Deceased	❑ Normally developed	❑ No significant disease	❑ Has/had: _____
Brother(s)	❑ Alive	❑ Deceased	❑ Normally developed	❑ No significant disease	❑ Has/had: _____
Sister(s)	❑ Alive	❑ Deceased	❑ Normally developed	❑ No significant disease	❑ Has/had: _____

CONTRAINDICATIONS

***Check** conditions that apply*

Relative

❑ Articular Hypermobility ❑ Anticoagulant Therapy
❑ Bleeding Disorder
❑ Radiculopathy w/ Progressive Neuro
❑ Severe Demineralization of Bone
❑ Benign Bone Tumor (Spine)

Absolute

❑ Acute Rheumatoid Arthritis
❑ Acute Fractures & Dislocations
❑ Unstable Os Odontoideum
❑ Ankylosing Spondylities
❑ Vertebral Malignancies
❑ Vertebral Infections
❑ Major Artery Aneurysm
❑ Vertebrobasilar Insufficiency
❑ Acute Arthropathies w/ Inflammation
❑ Unhealed Fractures & Dislocations
❑ Myelopathy or Cauda Equina Syndrome

SOCIAL HISTORY

Height: _____ Weight: _____

Diet: ❑ High fat ❑ High fiber ❑ High salt ❑ High protein
❑ Low carb ❑ Low fiber ❑ Low salt ❑ Low sugar ❑ Low calorie

Alcohol: ❑ N/A ❑ Socially ❑ Beer ❑ Wine ❑ Liquor ____ oz ____ glasses; ❑ Day ❑ Week ❑ Month

Tobacco: ❑ N/A ❑ Do not smoke cigars, cigarettes or pipe ❑ Live w/ smoker ❑ Quit tobacco
❑ Smoke; # ___ per ❑ Day ❑ Week ❑ Month
❑ Chew; # ___ cans per ❑ Day ❑ Week ❑ Month

Drugs: ❑ No illegal drug use ❑ No I/V drugs ❑ Have not used since: _____ ❑ Used since: _____