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Patient: ______________________________

Chief Complaint Form

Chief Complaint

Case Title: ______________________________

Describe the reason for your visit: ______________________________

When did your symptoms begin? (select one)

☐ Today ☐ This week ☐ Within last 3 months
☐ 3 months to 6 months ☐ 6 months to one year ☐ More than one year

For Women Only: Most recent menstrual cycle: ____/____/____

Are you pregnant? ☐ Yes ☐ No

Which word describes the frequency of your discomfort? (select one)

☐ Constant ☐ Intermittent ☐ Occasional ☐ Rare

Which phrases best describe *changes* in your discomfort during the day? (select one or more)

☐ It is worse in the morning ☐ It is worse in the afternoon ☐ It is worse at night
☐ It changes with the weather ☐ It does not change

What helps *relieve* your discomfort? (select one or more)

☐ Ice ☐ Heat ☐ Medication ☐ Other (please describe) ______________

What activities are limited by your discomfort? (select one or more)

☐ Bending ☐ Bowel Movements ☐ Coughing ☐ Daily Routine
☐ Driving ☐ Getting Up ☐ Lifting ☐ Lying Down
☐ Pulling ☐ Pushing ☐ Reading ☐ Sitting
☐ Sleeping ☐ Sneezing ☐ Standing ☐ Turning my head
☐ Urination ☐ Walking ☐ Working ☐ Other (please describe) ______________

Where applicable, specify the approximate date of your most recent: (month / year)

Physical Exam: ____/____ Dental X-rays: ____/____
Spinal X-ray: ____/____ CT Scan: ____/____
MRI: ____/____ Other Scans or X-rays: ____/____

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