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Chief Complaint Workup

Patient Name:_____ File #:_____
Date of Birth:_____ Date:_____

Chief Complaint/Patient's Description of Problem(s):_____
_____

DETAILS OF THE CHIEF COMPLAINT:

1. When or approximately when, did the complaint start? Date/Time:_____
2. Did it begin (please circle): gradually or suddenly
   a. IF in a wreck, draw a diagram, seatbelt? Airbags deploy? Head restraint position?
3. Describe the exact location(s) of the pain/problem(s).
4. Did anything cause or contribute to the onset? *Yes* *No* If yes, what as it_____
5. Can you describe the sensation you feel (please circle): Dull Sharp Burning Aching Throbbing
6. Does it radiate to any other part of your body? *Yes* *No* If yes, where: _____
7. How would you rate your intensity (severity) or complaint? _____
   (on a scale of 0-10, with 0 being no pain and 10 being the worst pain you can imagine)
8. Have you ever had an injury like this before? *Yes* *No*
   If yes, please describe:
9. Has your condition been (please circle): Contant Frequent Intermittent Occasional
10. Has your condition been getting (please circle): better or worst
11. What makes it better? (please circle): Rest, time of day, position, other:_____
12. What makes it worse? (please circle): Positions, coughing, sneezing, straining, bowel, other:_____
13. Does pain/problem change with (circle): the time of day or day of month
14. Changes in bodily functions: (please circle)
    Bowel, bladder, respiration, digestion, vision, sexual, other:_____
15. Has your condition affected your daily activities? *Yes* *No*
16. Have you tried over-the-counter or home remedies? *Yes* *No*
17. Have they helped? *Yes* *No*

18. Have you sought other professional care for this condition? *Yes* *No* If yes, where and who?_____

19. IF in a wreck: Police arrived *Y / N* Did ambulance arrive? *Y / N* Rode Ambulance? *Y / N*
    Did you go to the ER? *Y / N* If yes, which ER?_____

20. List the patient's medications, prescriptions/non-prescription medications:

21. List any Family History:

22. Other family history of spinal or <u>other health conditions:</u>

23. Do you have other symptoms or problems you wish to talk about? *Yes* *No*
    If yes, what symptoms is that?_____

24. <u>Presumed High-Risk Presenting History Category</u>
    (George's Cerebrovascular Cranioccervical Functional Test)
    A. Arteriosclerosis
    B. Transient ischemic attacks
    C. Hypertension
    D. Cardiovascular disease
    E. Use of oral contraceptives (type and how long)
    F. Cervical spine spondylosis
    G. History of Whiplash injury
    H. Family history of strokes
    I. Regular use of antihypertensive medication (e.g. Coumadin, heparin, aspirin, ect)

Allergies: _____

Surgeries:_____

Social History:_____

Past Medical History:_____

Exercise:_____

H2O Intake:_____

Injury History:_____

Sleep position: Stomach Side Back or varies

Additional Notes:

_____

_____

*Patient Signature:*_____ *Date:*_____

*Doctor Signature:*_____ *Date:*_____