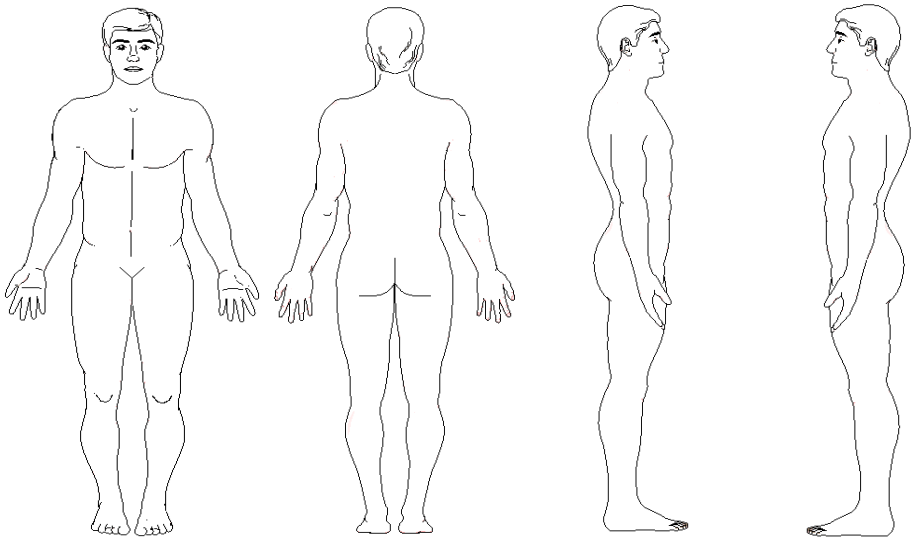
History of Present Illness- New condition

Name: DOB: Date:

Circle the type of pain you are experiencing:

- **Tightness**
- **Stiffness**
- **Aches**
- **Shooting**
- **Sharp**
- **Stabbing**
- **Dull**
- **Tingling**
- **Numb**
- **Throbbing**
- **Burning**

Mark on the bodies where you are experiencing pain



Date pain started:_____ What caused symptom(s)? _____

Please indicate the severity of your pain on a scale of **0-10** (0 being no pain, 10 being the worst possible pain)

Currently: _____ At its worst: _____ At its best: _____

Is the pain: ☐ Constant ☐ intermittent (Come and Go) Is it getting progressively worse? ☐ No ☐ Yes

What makes the pain worse? _____

What makes the pain better? _____

Does it radiate? ☐ No ☐ Yes To where? ☐ Right Arm ☐ Left Arm ☐ Right Leg ☐ Left Leg

What time of day is the pain worse ☐ Morning ☐ Noon ☐ Evening ☐ Night ☐ While Sleeping

Does your pain interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreational Activities

Which positions are most painful to do? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Do you have a history of pain previously? ☐ No ☐ Yes, when: _____

Mark all that you have tried for this complaint? ☐ Ice ☐ Heat ☐ Rest ☐ Advil/Tylenol ☐ other: _____

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

PATIENT SIGNATURE _____ DATE_____

PARENT/GUARDIAN SIGNATURE _____ DATE_____

Office use only:

Height: _____ Weight: _____ Temp: _____ BP: _____/_____ Pulse: _____ Resp: _____ Pt refused: _____