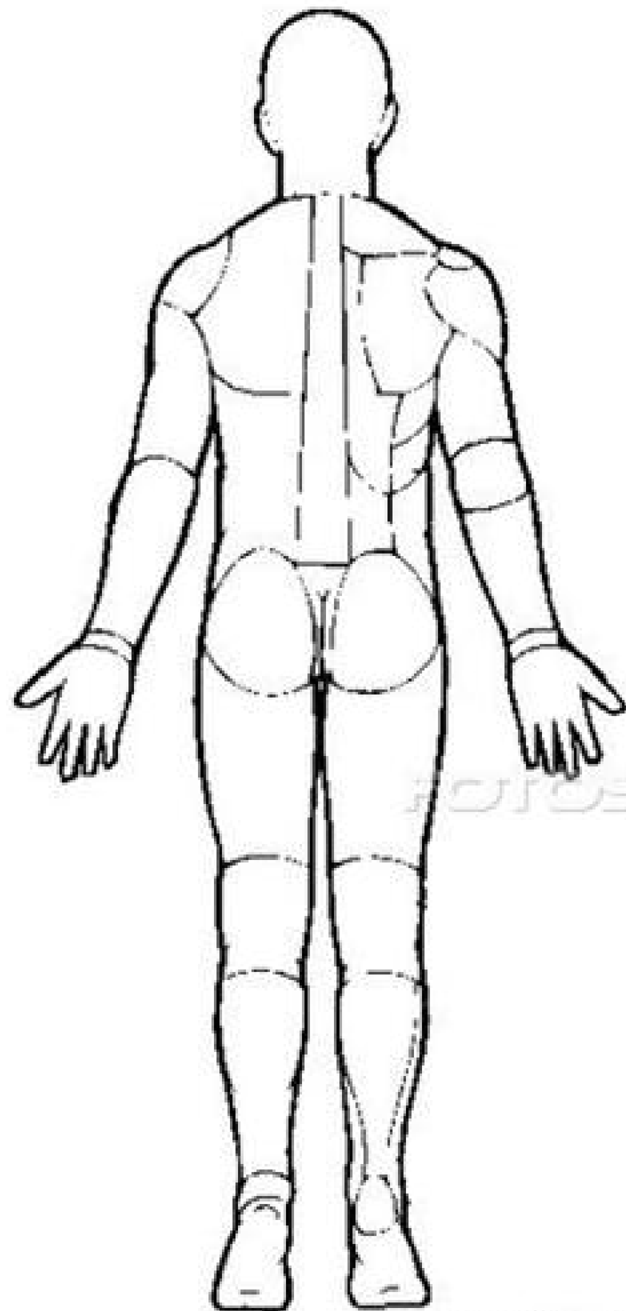
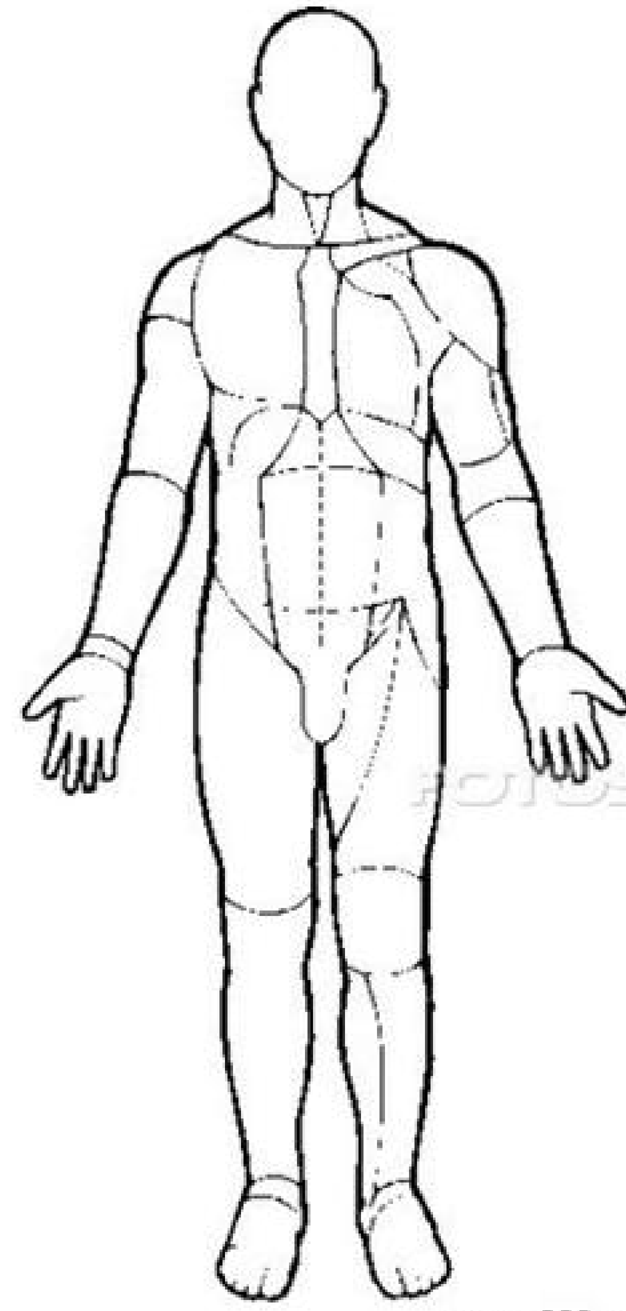
PATIENT HISTORY DISCUSSION

Name____ Date_______________

Patient: Mark the areas on your body where you feel the described sensations. Use the appropriate symbol and include all affected areas.

Numbness:	= = = =	Pins and Needles:	0 0 0 0
Burning:	X X X X	Stabbing:	/ / / / /





Primary Complaint:

A.	D.
B.	E.
C.	F.

Onset: (gradual, immediate) Date of Onset: Incident of onset:

What makes it better:

What makes it worse:

Duration of condition:

Quality:

Area__________________(sharp, dull, achy, burning, numbness, throbbing)

Area__________________(sharp, dull, achy, burning, numbness, throbbing)

Area__________________(sharp, dull, achy, burning, numbness, throbbing)

Intensity of pain:

Area______________________________(no) 1 2 3 4 5 6 7 8 9 10 (severe)

Area______________________________(no) 1 2 3 4 5 6 7 8 9 10 (severe)

Area______________________________(no) 1 2 3 4 5 6 7 8 9 10 (severe)

Getting Better Getting Worse Staying Same Level

Jeff Bratten, DC, 1155 NE Hogan Drive, Gresham, OR 97030 667-3366

Timing:	Area________________________________ (intermittent, constant) Area________________________________ (intermittent, constant) Area________________________________ (intermittent, constant)
Had problem previously:	
What previous treatment: Treated by: Was it effective:	
What are you doing for it now:	
Any doctors seen for any reason, including pregnancy:	
What drugs or home remedies are you taking:	
Have you found drugs or remedies effective:	
Have you had any serious falls, injuries, accidents, hospitalizations or surgeries, etc:	
Has this problem interfered with your job or living habits:	
Have you noticed any change in your functional habits: A. Bowel B. Bladder C. Other	