

Patient Condition Report

Patient: _____

Section 1

1. Main Complaint: _____

2. Is this injury due to: Work Auto Other

3. When did this complaint begin? _____

4. What caused this problem? _____

5. Please describe your symptoms _____
(i.e. sharp, dull, numb, achy, stiff sore, throbbing, tight)

6. Symptoms are worse: Morning Daytime Evening
(check all that apply)

7. The pain is: Constant Intermittent (comes and goes)

8. What activities make this condition feel worse:
 Sleeping Walking Sitting Standing Working Sports
 Other _____

9. What have you done to alleviate this condition? (Ice, Heat, Medication)

10. Have you seen other doctor(s) for this condition? No Yes
Please list doctor(s): _____

11. Have you noticed/experienced any other symptoms as a result of
this injury? No Yes Describe: _____

If you have additional comments, please use the back of this form.

Patient Signature: _____

File#: _____ Date: _____

Section 2

Please mark all areas of pain or injury on the illustrations below and give a word description of the symptoms you are experiencing in those areas.

Use the letters below to indicate the type and location of your sensations right now.

A=ACHE

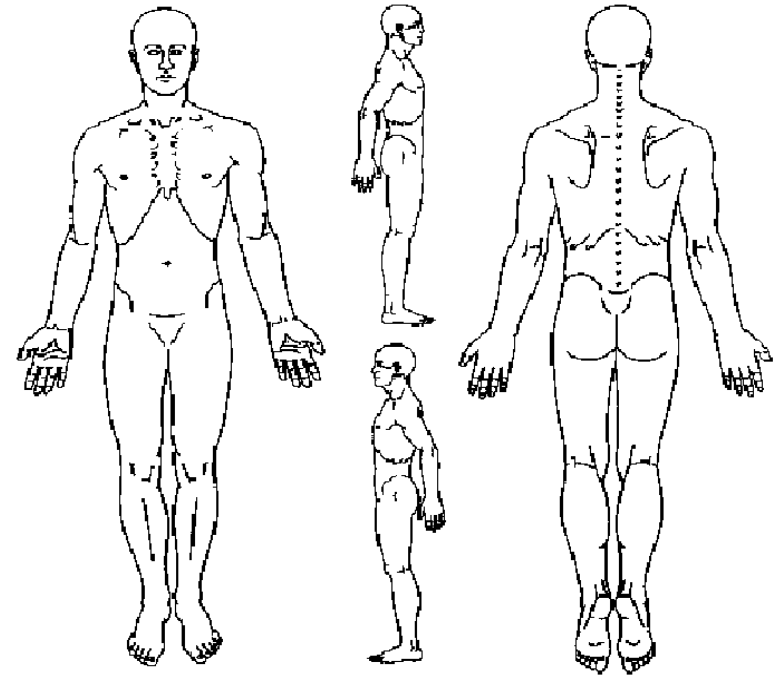
B=BURNING

N=NUMBNESS

P=PINS & NEEDLES

S=SHARPNESS

T=TIGHT/STIFF



Doctor's Comments: _____
