Name:
Chart:
Date:

GENERAL HISTORY

Name _____ Date of Birth _____

1. Reason for visit (include left or right) _____
2. Date of onset (beginning) of complaint/injury _____
3. Are you right or left handed? _____
4. Where did injury occur? _____
5. What activity were you engaged in? _____
6. How complaint happened (auto accident, work injury, fall, etc.) _____
   _____
7. Describe complaint (ache, pain, throb, lump, etc.) _____
8. Is there associated pain elsewhere? If so, describe _____
   _____
9. What is the effect of activity? Does it make the pain better or worse? _____
   _____
10. What is the effect of weather changes? _____
11. Any numbness or tingling in your arm or leg? _____
12. Any fever, chills, appetite loss, unexpected weight lose? _____
13. Does Aspirin/Tylenol/Advil, etc. help? _____
14. Does the pain awaken you from sleep? _____
15. Are there other symptoms? If so, describe _____
16. Describe any similar episodes in the past _____
17. Current treatment _____
18. Other physicians consulted for this problem? _____
19. Status now compared to onset? Better/worse/same _____
20. If off work because of this problem, state date last worked _____