CONSULTATION

Patient Name_____ DOB_____/_____/_____ Exam Date_____/_____/_____

Using **Black** or **Blue** ink, list **ALL** the **current** conditions you marked on Page 4 of your New Patient Paperwork; in **order of severity**.

Chief Complaints: List in order of Severity ***(Indicate if on Right side, Left Side, or Both)***	**When did you first notice this complaint?** (Use Weeks, Months, or Years.)	**Did your symptoms appear?** **S**=Suddenly **G**=Gradually	**What makes your symptoms worse?** (Specific examples: Lifting, Twisting, Bending, Sitting, Standing, Running, Walking.)	**How often do your symptoms bother you?** **D**=Daily **C**=Constantly **W**=Weekly **2x**=2x/month **M**=Monthly	**Rate your pain:** 0=No Pain 5=Moderate Pain 10=Worst Pain
EXAMPLE: SHOULDER PAIN; RIGHT SIDE	**3 WEEKS AGO**	**G**	**LIFTING; RUNNING**	**D**	**7**

Doctors Notes:

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Doctor's Signature _____ **Date Form Reviewed**: _____/_____/_____