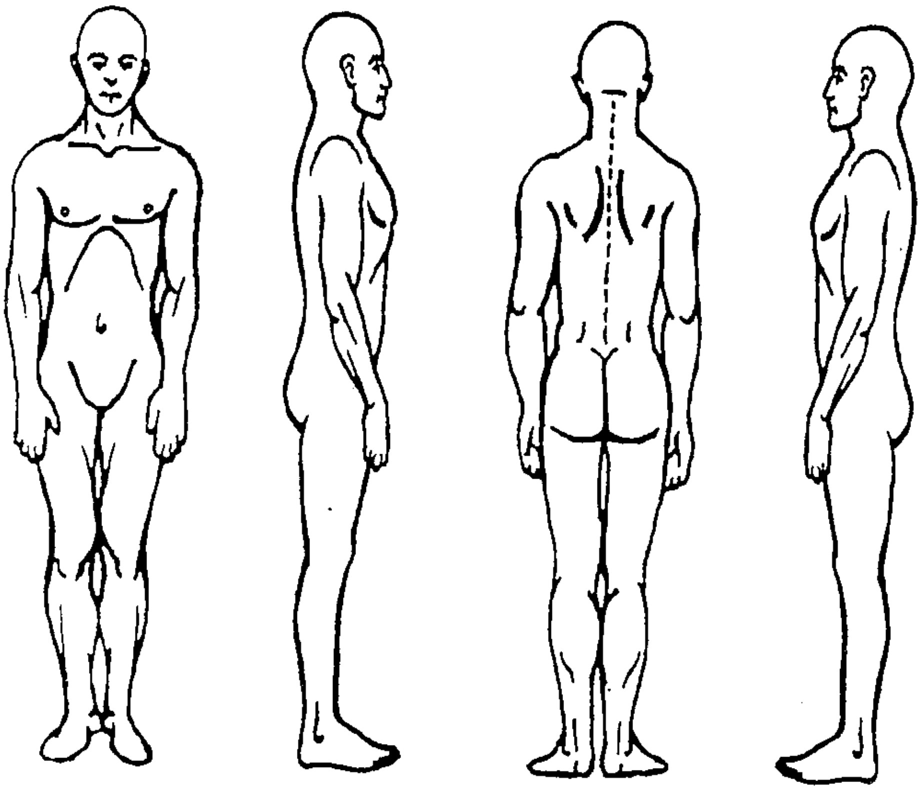
INITIAL PROBLEM RECORD

Major complaints and symptoms: ____

Date it first began: _____ / _____ / _____ Has this happened before? When? ________________

My symptoms were caused by: Fall _____ Sprain/Strain _____ Sports Injury _____ Other ______

Please mark your areas of complaint on the diagram below using the symbols on the right.



Aching ^^^^^^^^
Numbness +++++
Pins and Needles 00000
Burning XXXX
Stabbing or Sharp ////

Circle the number that best represents the level of pain/discomfort you are currently experiencing:

No Pain 1 2 3 4 5 6 7 8 9 10- Excruciating pain

What percentage of the time do you experience this problem? 0-25% 25-50% 50-75% 75-90% 90-100%

My pain is the worst when: ____

I am unable to perform the following daily activities: ________________________________

Have you had treatment by another medical professional for this same condition? Y _____ N _____

Name of medical professional/facility: ______________________________________

Diagnosis: ______________________________ Treatment: __________________

Provide dates of last: X-ray ___________ Physical Exam __________ Blood Test _____________

Name of Primary Care Physician: ____