ClearPoint WELLNESS

# CHIEF COMPLAINT

Date_____ Name _____

Chief complaint today: _____

Have had since: _____ Have you ever felt this before? If so when: _____

How did this condition begin this time / first time? _____

_____

What is the intensity of this feeling on a scale of 1 – 10 (10 being the most intense) at its worst point?____/10. At the best point?____/10 Is it Constant? Y N If it comes and goes, felt how often? **Daily Weekly Monthly**

What makes this condition better? _____

What makes this condition worse? _____

Describe this feeling (sharp, dull, achy, throbbing, tight, burning, etc.) _____

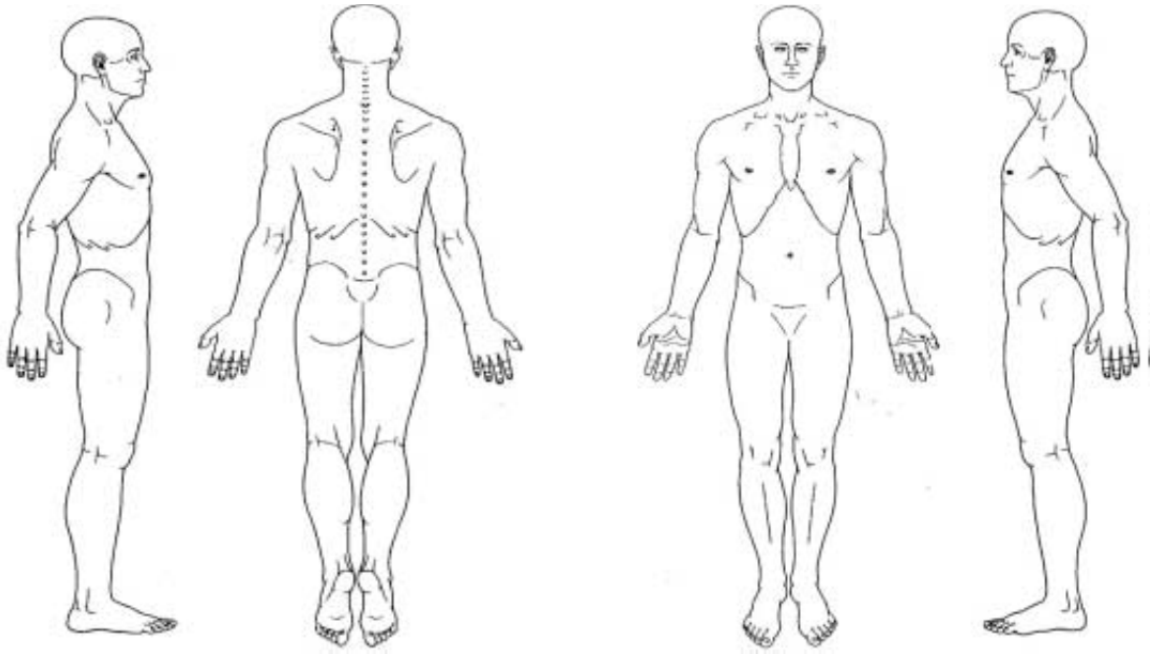
What part of the day is your condition is better? _____ Worse? _____

Have you seen any other health care practitioner for this condition? **Y N** If so, who and when? _____

_____

**Please draw on the body where your chief complaint is as well as any other current or past problem areas:**

X=pain, T=tight, P=pressure, N=numb, W=weak



Doctor's Notes: _____

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