Consultation

Patient:_____ Date:_____

Complaint #1	Complaint #2	Complaint #3
_____	_____	_____
_____	_____	_____
_____	_____	_____
Started When? _____	Started When? _____	Started When? _____
_____	_____	_____
Ever Before? _____	Ever Before? _____	Ever Before? _____
Better Worse Same	Better Worse Same	Better Worse Same
How Often? _____	How Often? _____	How Often? _____
_____	_____	_____
Radiate? _____	Radiate? _____	Radiate? _____
Describe: ☐ Sharp ☐ Achey ☐ Stiff/tight ☐ Numb ☐ Burning ☐ Tingly ☐ Dull ☐ Other _____	Describe: ☐ Sharp ☐ Achey ☐ Stiff/tight ☐ Numb ☐ Burning ☐ Tingly ☐ Dull ☐ Other _____	Describe: ☐ Sharp ☐ Achey ☐ Stiff/tight ☐ Numb ☐ Burning ☐ Tingly ☐ Dull ☐ Other _____
Intensity 0-10 (10 being worst)	Intensity 0-10 (10 being worst)	Intensity 0-10 (10 being worst)
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Anything make it better or worse?	Anything make it better or worse?	Anything make it better or worse?
_____	_____	_____
_____	_____	_____
Notes: _____	Notes: _____	Notes: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Doctor's Notes:

Significant Illnesses, Trauma, Surgeries:

Doctor's Signature:	Date of Consultation: