

Chief Complaint – HPI (History of Present Illness)

Patient Name: _____ Case: _____ Date: _____ Dr: _____

Chief Complaint: _____

Body Area(s) Involved: Cervical Spine, Ribs, Pelvis Upper Extremity Lower Extremity

Condition: New → Acute or Chronic
 Recurrence (Acute) Exacerbation (Acute) Chronic

Mechanism of Onset:

Auto Driver/Passenger Pedestrian (refer to completed auto accident history form)

Work Related: Fall Falling Object Lifting Overexertion Repetitive Motion

Other: _____

(refer to completed work accident history form)

Other – Liability: _____ Slip or Fall Other: _____

Other – No Liability: Etiology Unknown Overexertion Repetitive Use Slept Wrong Slip or Fall

Other: _____

No Injury

Description of Onset of Complaint: _____

Current Symptoms: Pain Numbness Stiffness Weakness

Location: Left / Right / Bilateral _____

Quality: Burning Diffuse Dull/Aching Localized Radiating Sharp Shooting
 Stabbing Throbbing Tightness Tingling Other _____

Level of Impairment Due to Symptoms (Resting):

0 1 2 3 4 5 6 7 8 9 10

Level of Impairment Due to Symptoms (With Activity):

0 1 2 3 4 5 6 7 8 9 10

Duration: _____ Started: _____

Last Occurred: _____ Last episode: _____ Resolved Previous Visit: _____

Worsened: _____ Injury Occurred: _____ Accident Occurred: _____

Timing: *Worse:* Morning Afternoon Night with Activity; Constant Intermittent

Context: *Better with:* Warm Temp Cold Temp *Worse with:* Warm Temp Cold Temp Damp

Assoc Signs and Symptoms: Blurred Vision Depression Dizziness Irritability/Mood Swing
 Localized Tingling Nausea Ringing in Ears Sleep Disturbance Stiffness

Headaches: Location: Occipital Frontal Left Temporal Right Temporal Parietal Sinus

Quality: Dull Sharp Throbbing Stabbing Aura No Aura

Types: Hat Band Cluster Migraine Tension

Other: (frequency/duration/time of day) _____

Radiation: Left / Right / Bilateral _____
Weakness: Left / Right / Bilateral _____

Other Assoc Signs and Symptoms:

- | | | | | |
|---------------------------------------|--|--|--|---|
| <input type="checkbox"/> aches | <input type="checkbox"/> burning | <input type="checkbox"/> cold limb(s) | <input type="checkbox"/> difficulty walking | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> ecchymosis | <input type="checkbox"/> chronic fatigue | <input type="checkbox"/> fever | <input type="checkbox"/> heartburn | <input type="checkbox"/> joint stiffness |
| <input type="checkbox"/> muscle spasm | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> nausea | <input type="checkbox"/> numbness | <input type="checkbox"/> pale bluish skin |
| <input type="checkbox"/> panic | <input type="checkbox"/> pins & needles | <input type="checkbox"/> rhinorrhea (runny nose) | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> sweating |
| <input type="checkbox"/> swelling | <input type="checkbox"/> tingling | <input type="checkbox"/> vomiting | | |

Modifying Factors:

- Symptoms Better With: nothing helps activity bending applying cold applying heat
 massage movement OTC meds Rx meds rest
 stretching sitting standing twisting walking

Symptoms Worse With: (as noted in Social History)

- Since condition began, has anything permanently helped you? YES NO
Has anything that you have done, thus far, fixed you problem? YES NO

Employment:

Occupation/Job Title: _____ Work: _____ hrs / day or week

Description of Work:

- Job Classification: Sedentary (<5lbs) Light (5-20lbs) Moderate (20-50lbs) Heavy (>50 lbs)
Lifting Frequency: Constant (67-100%/day) Frequent (33-66%/day) Occasional (0-32%/day)
Lifting Postures: with Arms High Near from Knee Off Posture from Torso

Work Activity Postures: (hrs/day)

- bending: _____ h/d climbing: _____ h/d kneeling: _____ h/d pulling: _____ h/d pushing: _____ h/d
 reaching: _____ h/d sitting: _____ h/d standing: _____ h/d twisting: _____ h/d walking: _____ h/d

Repetitive Activities: (hrs/day)

- assembly/fine manipulation: _____ h/d computer use/typing: _____ h/d grasping: _____ h/d
 hand tool use: _____ h/d operation of machinery controls: _____ h/d phone use: _____ h/d

Condition's Effect On Job Performance:

- Mild Painful (Can do) Mod Painful (limited ability) Mod/Sev Limited Duty Sev No Limited Duty Sev (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

- | | | | | |
|--------------------------|------------------------------------|--|--|--|
| Bending: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Care—Infirm Family: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Carrying Groceries: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Change Posn—Sit—Stand: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Climb Stairs: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Driving: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Extended Computer Use: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Feeding: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Household Chores: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Kneeling: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Lift Children: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Lifting: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Pet Care: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Reading (Concentration): | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Self Care—Bathing: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Self Care—Dressing: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Self Care—Shaving: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Sexual Activities: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Sleep: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Static Sitting: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Static Standing: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |

Walking: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
Yard Work: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

_____ **No Effect** **Mild** Painful (Can do) **Mod** Painful (limited) **Sev** Unable to Perform
_____ **No Effect** **Mild** Painful (Can do) **Mod** Painful (limited) **Sev** Unable to Perform