Chief Complaint

NAME_____ DATE_____

CHIEF COMPLAINT:
(This is the main reason you are seeing the doctor such as back pain, neck pain etc)

ONSET:
(When and how it started)

LOCATION:
(Exactly where it is such as right lower back, left arm etc.)

QUALITY OF PAIN: Dull ache, Sharp, burning, tingling, radiating
(circle all that apply)

DURATION:
(how long during the day do you have pain)

FREQUENCY:
(How often during the day does the pain come)

RELIEVING FACTORS:
(Things you have been able to do that have helped like heat, ice, sitting, pain medication)

AGGRAVATING FACTORS:
(Things you do that make the pain worse like standing, lifting)

MEDICATION:
(Any medication you are taking now for this complaint)

OTHER TREATMENT:
(Any other doctors or treatment you have seen or had and if any has helped)

RELATED SYMPTOMS:
(any other pains that you think might be connected to this main complaint)

OTHER COMPLAINTS:
(a complete list by name of other health complaints in order of severity)

The Personal Injury and Industrial Accident Clinic
4211 Holladay Blvd. – Salt Lake City, UT 84124 – (801)272-8471