PLEASE FILL OUT THIS QUESTIONNAIRE.
BRING IT WITH YOU TO YOUR APPOINTMENT

PM&R Tower Health
2802 Papermill Road
Wyomissing, PA 19610
484-628-2778

CHIEF COMPLAINT FORM

Name:	Date:	Age:	Date of Birth:	Dominant Hand: ☐ Right ☐ Left

This information will assist in determining the cause of your symptoms.

1. Describe your main problem: _____

_____
_____
_____

2. The main problem began: ☐ Suddenly ☐ Gradually

3. How long have you had the problem?
☐ Years ☐ Months ☐ Weeks ☐ Days

4. What were you doing when this problem began?

_____

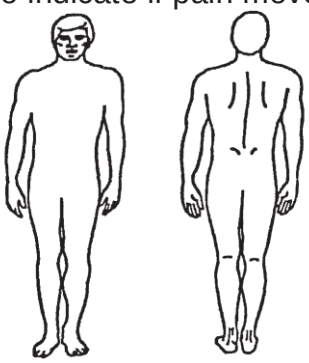
5. Does the pain wake you up? ☐ Yes ☐ No

6. Are you weak?

☐ Lifting	☐ Left	☐ Right
☐ Grasping	☐ Left	☐ Right
☐ Knee Buckling	☐ Left	☐ Right
☐ Tripping	☐ Left	☐ Right
☐ Falling	☐ Left	☐ Right
☐ Other	☐ Left	☐ Right

7. Mark the location of your problem

Place an "X" at the most painful areas
Draw an arrow to indicate if pain moves to another area



8. What does the pain feel like?

☐ Dull Ache	☐ Strong Ache	☐ Cramping
☐ Pulling	☐ Sore	☐ Heavy
☐ Burning	☐ Stabbing	☐ Shooting
	☐ Pins/Needles	☐ Tingling

☐ Numbness-Decreased Sensation
☐ Other: _____

9. Intensity of Pain:

0 = No Pain *10 = Worst Pain Imaginable*

0 1 2 3 4 5 6 7 8 9 10

What number describes your pain at its worst? _____

What number describes the least level of your pain? _____

What number describes the average amount of your pain? _____

10. What treatment(s) have you previously tried? (circle)

Surgery	Acupuncture
Physical Therapy	Injections
Chiropractic	None

OVER

Name:	Date:	Date of Birth:

What medication(s) have you tried? (check)

☐	Tylenol	☐	Aspirin	☐	Naproxen
☐	Ibuprofen	☐	Codeine	☐	Hydrocodone
☐	Oxycodone	☐	Ultram	☐	Gabapentin
☐	Lyrica	☐	Cymbalta	☐	Tizanidine
☐	Methocarbamol/Robaxin	☐	Flexeril/Cyclobenzaprine		

11.Review of Systems (recent symptoms):

Please circle YES or NO if you have had the following symptom(s) ever or in the last year?

			COMMENTS
Weight gain / loss	Yes	No	
Headache	Yes	No	
Visual loss	Yes	No	
Hearing loss	Yes	No	
Neck stiffness	Yes	No	
Joint pain	Yes	No	
Joint stiffness	Yes	No	
Chest pain	Yes	No	
Limb swelling	Yes	No	
Shortness of breath	Yes	No	
Memory problem	Yes	No	
Depression/Anxiety	Yes	No	
Sleep disorder	Yes	No	
Local weakness	Yes	No	
Fainting spell	Yes	No	
Falling	Yes	No	
Lose control of stool	Yes	No	
Lose control of urine	Yes	No	

Signature of Patient Date

For Office Use Only

Signature of Physician Date Time