

## 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: \_\_\_\_\_  
 Other – Liability:  Slip or Fall  Other: \_\_\_\_\_  
 Other – No Liability:  Etiology Unknown  Overexertion  Repetitive Use  Slept Wrong  Slip or Fall  
 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                |  |   |