Name:____ Date: _______________

Which of the following describes your present problem? ☐ No obvious cause ☐ Sudden onset of pain: ☐Gradual onset ☐ An Illness ☐ An Injury ☐ A motor vehicle collision ☐ A personal injury 3rd party at fault ☐ A work related injury ☐ Other (describe): ____

Enter the date of the injury, illness or onset of pain: ______________

In the blanks provided, list any **symptoms** that you experienced **IMMEDIATELY** after the injury, illness, or onset of pain: Then choose the appropriate pain descriptions.

1. ____________________ ☐(1) Very Mild ☐(2) ☐(3) ☐(4) ☐(5) ☐(6) ☐(7) ☐(8) ☐(9) ☐(10) Remarkably Severe

   Frequency of Pain: ☐ None ☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant

   Type of Pain: ☐ None ☐ Aching ☐ Burning ☐ Dull ☐ Pulling ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Stinging ☐ Throbbing

2. ____________________ ☐(1) Very Mild ☐(2) ☐(3) ☐(4) ☐(5) ☐(6) ☐(7) ☐(8) ☐(9) ☐(10) Remarkably Severe

   Frequency of Pain: ☐ None ☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant

   Type of Pain: ☐ None ☐ Aching ☐ Burning ☐ Dull ☐ Pulling ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Stinging ☐ Throbbing

3. ____________________ ☐(1) Very Mild ☐(2) ☐(3) ☐(4) ☐(5) ☐(6) ☐(7) ☐(8) ☐(9) ☐(10) Remarkably Severe

   Frequency of Pain: ☐ None ☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant

   Type of Pain: ☐ None ☐ Aching ☐ Burning ☐ Dull ☐ Pulling ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Stinging ☐ Throbbing

4. ____________________ ☐(1) Very Mild ☐(2) ☐(3) ☐(4) ☐(5) ☐(6) ☐(7) ☐(8) ☐(9) ☐(10) Remarkably Severe

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   Type of Pain: ☐ None ☐ Aching ☐ Burning ☐ Dull ☐ Pulling ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Stinging ☐ Throbbing

List any **symptoms** you are experiencing **TODAY**: ☐ **Same as indicated above (no changes)**

1. ____________________ ☐(1) Very Mild ☐(2) ☐(3) ☐(4) ☐(5) ☐(6) ☐(7) ☐(8) ☐(9) ☐(10) Remarkably Severe

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   Type of Pain: ☐ None ☐ Aching ☐ Burning ☐ Dull ☐ Pulling ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Stinging ☐ Throbbing

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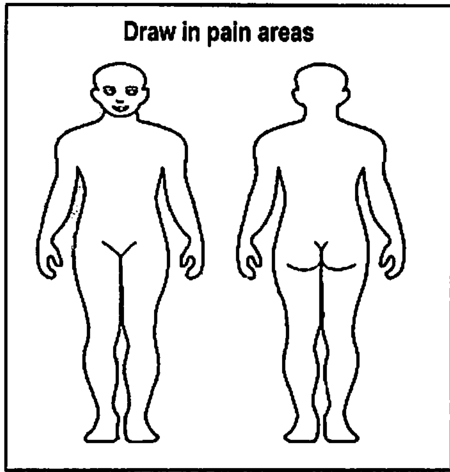

Enter a Full Description of your Complaint, Condition, Accident, or Injury:
(when, where, how, & what hurts) ____________________

HABITS	EXERCISE	FAMILY HISTORY	Diabetes	Cancer	Back Pain	Other
❑Smoking Packs/day: _____	❑None					
❑Alcohol/day): _____	❑Moderate	Mother	❑	❑	❑	❑___
❑CoffeeCups/Day: _______	❑Daily	Father	❑	❑	❑	❑___
❑Soda/Day: _____	Type Ex: ________	Brother(s)	❑	❑	❑	❑___
❑Water Oz/Day: _______	___________	Sister(s)	❑	❑	❑	❑___

List any current medications you take:____________________

List any current supplements you take:____________________

List any current allergies:____________________

List any PAST surgeries? (enter the type and approximate date of surgery):

CIRCLE BELOW ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE NOW, OR HAVE HAD BEFORE:

Alcoholism	Chicken Pox	Measles	Rheumatic Fever
Anemia	Epilepsy	Mental Disorder	Tuberculosis
Appendicitis	Flu	Mumps	Venereal Ds
Cancer	HIV / AIDS	Polio	Whooping Cough

I hereby authorize Dr. Pearce to examine me.

Print Name: ____________________

Patient's/Guardian's Signature: ____________________ Date: __________