NAME: _____ DOB: _____

Evolutionary Medicine LLC

Health Concerns

Primary Complaint: _____ Date of Onset: _____

Cause of Symptoms? _____

How did it come on? _____

Symptoms are *(Circle)*: Constant / Intermittent Does the intensity of the symptoms fluctuate? Y / N

When (during day) is your pain the worst? _____ When is it best? _____

Quality *(Circle)*: *Stabbing / Aching / Burning / Throbbing / Dull / Sharp / Penetrating / Radiating / Tingling / Numb*

Pain Scale: *(Circle)* NOW: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Highest over the PAST 2 WEEKS: 0 1 2 3 4 5 6 7 8 9 10

Lowest over the PAST 2 WEEKS: 0 1 2 3 4 5 6 7 8 9 10

What aggravates your pain? _____

What relieves your pain? _____

Medications for the problem (e.g. – Opioids, Antidepressants, Muscle Relaxants, Anti-inflammatories, etc):

Name / Type	Helpful?	Name / Type	Helpful?

Other treatments / therapies for the problem (e.g. – Massage, Chiropractic, Physical Therapy, etc):

Type	Helpful?	Type	Helpful?

Labwork / Diagnostic Imaging (e.g. – X-Ray, MRI, CT SCAN, CBC, etc):

Study	Date	Body Part	Result / Diagnosis

Secondary Complaint: _____ Onset: _____

Caused By: _____ Pain Level (0 – 10): _____

Location / Quality of Pain: _____

History of Secondary Complaint (including Medications, Treatments, Labwork):