Ouch Form

Change of Condition Report

If you have experienced a sudden change in your physical condition, we would like to know about it because we want your treatment to be the best possible for your present state. Your complete recounting of any discomfort you have felt, and any accidents or injuries you have had recently, even if you experienced no apparent reaction, will help us help you more. Please provide us with the information requested below.

Name: ____

Date of Accident or onset of condition: ________________________________

Describe in detail any **RECENT** falls, accidents, or aggravation of an old condition you have had since your last visit or anything that you have done to aggravate a condition:

____
____
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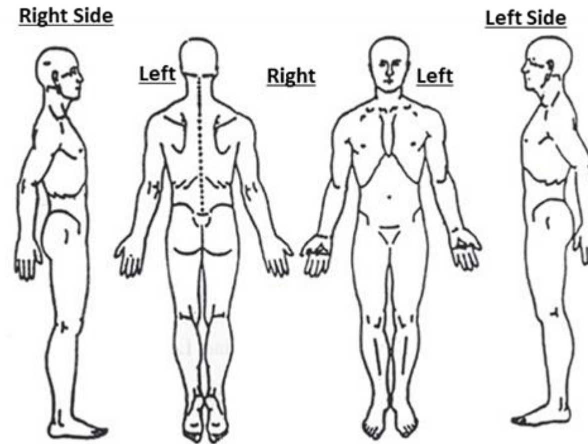
Mark any areas of pain, discomfort, or other symptoms you have experienced since your last visit:

Pain Areas	Numbness Areas	Other Symptoms
☐Headache	☐Head	☐ Muscle Spasm
☐Neck	☐Neck	☐Achy
☐Upperback	☐Upperback	☐Sharp
☐Shoulders Rt/Lt	☐Shoulders Rt/Lt	☐Stabbing
☐Elbows Rt/Lt	☐Arms Rt/Lt	☐Piercing
☐Wrist Rt/Lt	☐Hands Rt/Lt	
☐Hands Rt/Lt	☐Midback	
☐MidBack	☐Ribs Rt/Lt	
☐Ribs Rt/Lt	☐Lowback	
☐Lowback	☐Hips Rt/Lt	
☐Hips Rt/Lt	☐Legs Rt/Lt	
☐Knees Rt/Lt	☐Feet Rt/Lt	
☐Ankles Rt/Lt	☐Other ______________	
☐Feet Rt/Lt		
☐Other ______________		



Does the pain, discomfort, or other symptoms:
☐ Come and go { ☐More pain then not ☐Mostly pain free during day }
☐ Constant

Do you have to take breaks throughout the day due to pain? ☐Yes ☐No

What daily activities are you unable to do due to the pain?
☐Personal Grooming ☐Employment ☐Homemaking ☐Lifting
☐Sitting ☐Sleeping ☐Standing ☐Traveling ☐Walking
☐Other:____

What have you done to try to relieve your symptoms?
☐Ice ☐Heat ☐Pain Medication ☐Massage ☐Acupuncture
☐Other Doctor:_____________________Date:__________________
☐Other:____

Patient (or Parent/Guardian) Signature:__________________________________ Today's Date:____________________________

(office Use)Ck By:___________