

# HISTORY OF CURRENT CONDITION



**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

1. What are your symptoms: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. When did your symptoms begin? \_\_\_\_\_

3. Was the **onset** of this episode gradual or sudden? \_\_\_\_\_

4. How did your injury occur and/or symptoms begin? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Since the onset, are your symptoms:  getting worse  getting better  no change

6. Have you had similar symptoms in the past?  yes  no  
If yes, more than one episode? other: \_\_\_\_\_

7. What is the nature of your pain? sharp dull aching throbbing  
(Circle all that apply) other: \_\_\_\_\_

8. How often does your pain occur?  periodic  occasional  
 constant  no pain

9. As the **DAY** goes on, do your symptoms get:  worse  better  no change

10. Does the pain wake you at night?  yes  no  no pain

11. In what position do you sleep? right side left side stomach  
(Circle all that apply) back chair/recliner  
other: \_\_\_\_\_

