OUCH!

Change of Condition Report

If you have experienced a sudden change in your physical condition, we would like to know about it. Knowing how you are doing helps us provide you with the most appropriate and safest treatments. Please describe in detail any discomfort, accidents or injuries since your last treatment.

NAME ____ DATE __________________

WHAT Since your last, visit have you had any of the following? If yes, please tell when and how.

- ○ Falls ____
- ○ Accidents ____
- ○ Injuries ____

List any new symptoms ____

When did these symptoms begin? ____

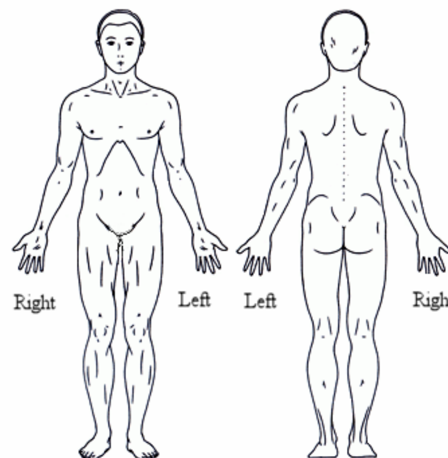
What brought these symptoms on? ____

WHERE Please show where and how badly it hurts.

A = Ache B = Burning N= Numbness
P = Pins & Needles S = Stabbing O = Other

PAIN SCALE
Please circle the number that best describes your pain.

0 1 2 3 4 5 6 7 8 9 10
NONE SLIGHT MODERATE SEVERE



TREATMENT Please list any treatments you have used or other care you have received.

- ○ Ice
- ○ Heat
- ○ Pain Relievers ____________________
- ○ Supplements/Herbs ________________
- ○ Other ____
- ○ Other physician care:
  - o What ____
  - o Where ____
  - o When ____

OFFICE USE:

DATE OF LAST VISIT _______________________

PATIENT ACCOUNT # _______________________