Inside Sports Clinic
11301 W 88th Street
Overland Park, KS 66214
p 913.888.4845
f 913.888.9248
insidesportsclinic.medicfusion.com

Patient: _____

Chief Complaint Form

Chief Complaint

Case Title: _____

Describe the reason for your visit: _____

_____

_____

When did your symptoms begin? (select one)

☐ Today ☐ This week ☐ Within last 3 months

☐ 3 months to 6 months ☐ 6 months to one year ☐ More than one year

For Women Only: Most recent menstrual cycle: ____/____/____

Are you pregnant? ☐ Yes ☐ No

Which word describes the frequency of your discomfort? (select one)

☐ Constant ☐ Intermittent ☐ Occasional ☐ Rare

Which phrases best describe *changes* in your discomfort during the day? (select one or more)

☐ It is worse in the morning ☐ It is worse in the afternoon ☐ It is worse at night

☐ It changes with the weather ☐ It does not change

What helps *relieve* your discomfort? (select one or more)

☐ Ice ☐ Heat ☐ Medication ☐ Other (please describe) _____

What activities are limited by your discomfort? (select one or more)

☐ Bending ☐ Bowel Movements ☐ Coughing ☐ Daily Routine

☐ Driving ☐ Getting Up ☐ Lifting ☐ Lying Down

☐ Pulling ☐ Pushing ☐ Reading ☐ Sitting

☐ Sleeping ☐ Sneezing ☐ Standing ☐ Turning my head

☐ Urination ☐ Walking ☐ Working ☐ Other (please describe) _____

Where applicable, specify the approximate date of your most recent: (month / year)

Physical Exam: ____/____ Dental X-rays: ____/____

Spinal X-ray: ____/____ CT Scan: ____/____

MRI: ____/____ Other Scans or X-rays: ____/____

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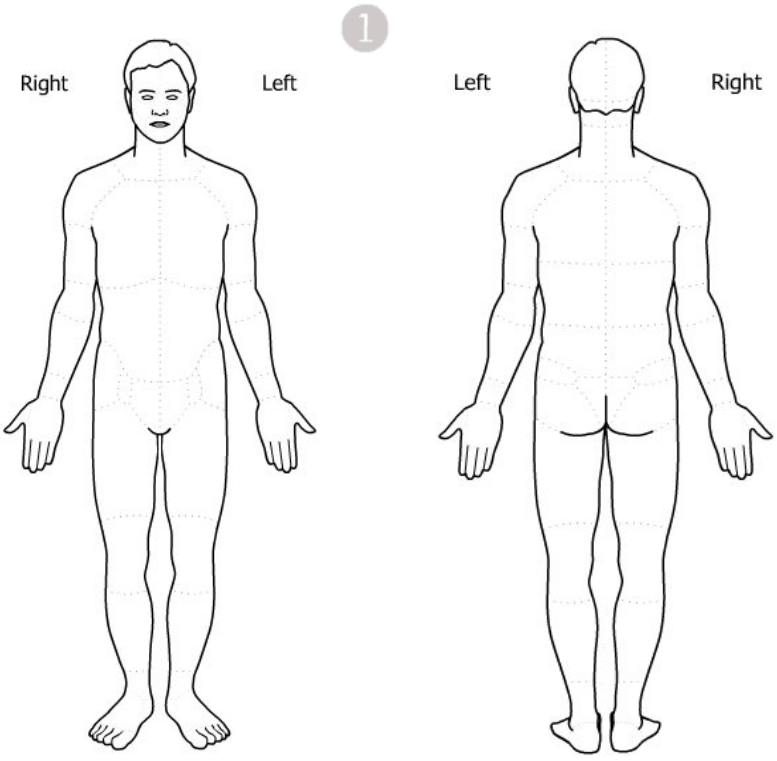
Patient: _____

Patient Symptom Illustrator

Patient Symptom Illustrator

Front **Back**



Instructions:

1 Identify your areas of discomfort by marking the affected body parts in the illustration.

2 Indicate the area name along with your specific symptoms associated with each selected area.

3 Rate your discomfort associated with each selected area.

		2 Burning	Dull Ache	Sharp Stabbing	Throbbing	Numbness	Pins and Needles	Spasm	Swelling	Stiffness	3 0 = No Discomfort 10 = Severe Discomfort
Ex.	L (R) Lower Back			X			X			X	0 1 2 3 4 5 6 X 8 9 10
1.	L R										0 1 2 3 4 5 6 7 8 9 10
2.	L R										0 1 2 3 4 5 6 7 8 9 10
3.	L R										0 1 2 3 4 5 6 7 8 9 10
4.	L R										0 1 2 3 4 5 6 7 8 9 10

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Physician Form

Physician Information

Type of Physician: ☐ Chiropractic ☐ Family ☐ Specialist

Physician Name: _____
First Name *Last Name*

Address: _____
Street Address *Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Ext. _____ Fax: _____

Email Address: _____

Type of Physician: ☐ Chiropractic ☐ Family ☐ Specialist

Physician Name: _____
First Name *Last Name*

Address: _____
Street Address *Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Ext. _____ Fax: _____

Email Address: _____

Type of Physician: ☐ Chiropractic ☐ Family ☐ Specialist

Physician Name: _____
First Name *Last Name*

Address: _____
Street Address *Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Ext. _____ Fax: _____

Email Address: _____