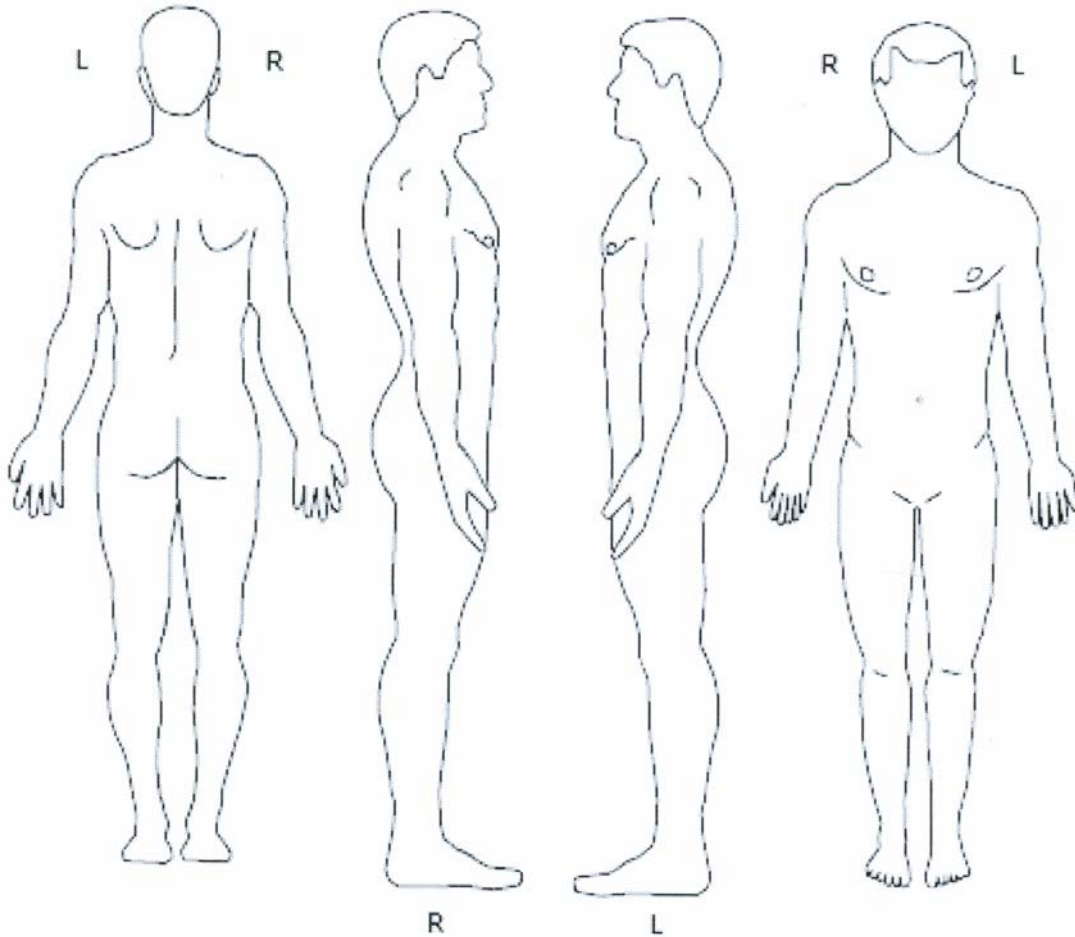


Patient's Complaints

Name: _____ Date: _____ Case Number: _____

1. On the Diagram, Mark where your pain or discomfort is. (May experience more than one.)



Mark as follows:

P – Pain N – Numbness T – Tingling St – Stiffness
 So – Soreness Sw – Swelling W – Weakness

Put a number next to the letter for pain level. Example “P3”

Mark an X in the box below the number indicating your level of pain.

0	1	2	3	4	5	6	7	8	9	10

No
Pain

Moderate
Pain

Worst Possible
Pain

2. How Did Your complaint (s) Begin?

- Unknown Suddenly Gradually

3. What Happened to Cause Or Re-Aggravate Your Complaint(s)?

- Cause Not Known Auto Accident Work Accident/Injury Home Accident
 Personal Injury Sport Injury
 Other _____

4. When Are Your Symptoms Worse?

- Morning Afternoon Evening Night Always The Same

5. What Makes Your Condition Better?

- Nothing Stretching Heat Rest Exercise Ice Sitting
 Standing Medications Other _____

6. What Makes Your Condition Worse?

- Nothing Coughing Reaching Standing Sneezing Lifting
 Sitting Pulling Bending Walking Straining at Stool Turning
 Other _____

7. Have Any Of Your Complaint(s) Existed In The Past? Y N

if Yes, Indicate Below

- Neck Upper Back Mid Back Low Back Ribs
 Shoulder Arm Elbow Forearm Wrist Hnd/Fgrs
 Buttock Hip Thigh Knee Leg/Calf Ankle
 Foot Others: _____

8. Have You Had Any Recent Treatment For Your Conditions OUTSIDE Of This Office?

- Yes No If Yes, List Dates, Treatment, and Doctors

9. Since Your Symptoms Began, Have You Noticed A Change In?

- Bowel Function... Yes No
Bladder Function... Yes No
Sexual Function... Yes No