KLINGERT CHIROPRACTIC CENTER **ADDITIONAL COMPLAINT**

Name: _____ Date: _____ File#: _____

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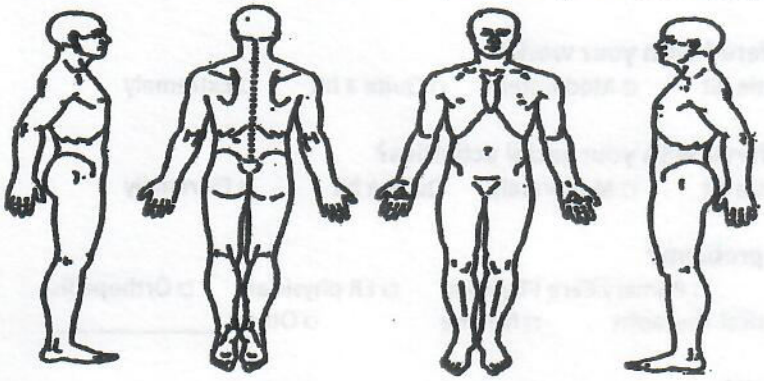
ADDITIONAL AREA OF COMPLAINT

Indicate on the drawings below where you have your second/third problem area:



SECOND/THIRD MOST BOTHERSOME COMPLAINT: _____

(L / R = Left / Right)

□ Head	(□ Entire Head	□ Base of Skull	□ Forehead	□ Temples)
□ Neck L / R	□ Shoulder L / R	□ Elbow L/R	□ Migraine	□ Hand L / R
□ Mid Back L / R	□ Upper Mid Back L / R	□ Lower Mid Back L / R	□ Rib Cage L / R	
□ Low Back L / R	□ Hip L / R	□ Knee L / R	□ Foot L / R	
□ Other L / R _____				

1. Using a scale from 0-10 (10 being severe, tearful type pain), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)
None Mild Moderate Severe Tearful

2. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

3. How would you describe the type of pain?

□ Sharp	□ Numb	□ Dull
□ Tingling	□ Diffuse	□ Sharp with motion
□ Achy	□ Shooting with motion	□ Burning
□ Stabbing with motion	□ Shooting	□ Electric-like with motion
□ Stiff	□ Other:_____	

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Name: _____ File#: _____

4. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

5. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

6. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

7. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician □ ER physician □ Orthopedist
□ Massage Therapist □ Physical Therapist □ No one □ Other:_____

Diagnosis _____ Results _____

8. How long have you had this problem? _____

9. How do you think your problem began?

_____

10. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

11. What aggravates your problem? **(L / R = Left / Right)**

□ Coughing	□ Bend Forward	□ Walking	□ Running
□ Sneezing	□ Bend Backward	□ Sitting	□ Climb Stairs
□ Straining	□ Rotation L / R	□ Lying	□ Quick Movements
□ Bowel Movement	□ Side Bending L / R	□ Standing	□ Lifting _____ pounds
□ Work at Computer	□ Other _____		

12. What makes the problem better?

□ Nothing	□ Stretching	□ Heat	□ Rest
□ Exercise	□ Ice	□ Sitting	□ Standing
□ Prescription Medications		□ Over the Counter Medications	
□ Other _____			

13. What concerns you the most about your problem; what does it prevent you from doing?

□ It could be serious. □ It is affecting leisure activity.
□ It isn't going away. □ It is affecting work.
□ It is getting worse. □ Other _____

14. Have you ever had this problem before? Yes / No
Please describe _____

Patient Signature: _____ **Date:** _____