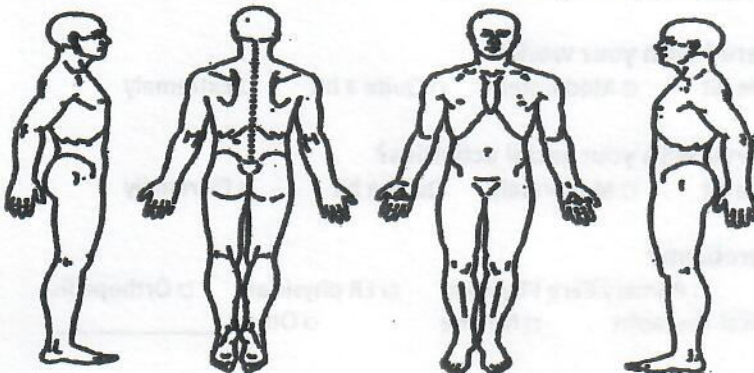


Name: _____ Date: _____ File#: _____

2

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) Migraine
- Neck L / R Shoulder L / R Elbow L/R 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: _____

2

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)

- | | | | |
|---|---|-----------------------------------|---|
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Bend Forward | <input type="checkbox"/> Walking | <input type="checkbox"/> Running |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> Bend Backward | <input type="checkbox"/> Sitting | <input type="checkbox"/> Climb Stairs |
| <input type="checkbox"/> Straining | <input type="checkbox"/> Rotation L / R | <input type="checkbox"/> Lying | <input type="checkbox"/> Quick Movements |
| <input type="checkbox"/> Bowel Movement | <input type="checkbox"/> Side Bending L / R | <input type="checkbox"/> Standing | <input type="checkbox"/> Lifting _____ pounds |
| <input type="checkbox"/> Work at Computer | <input type="checkbox"/> 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: _____