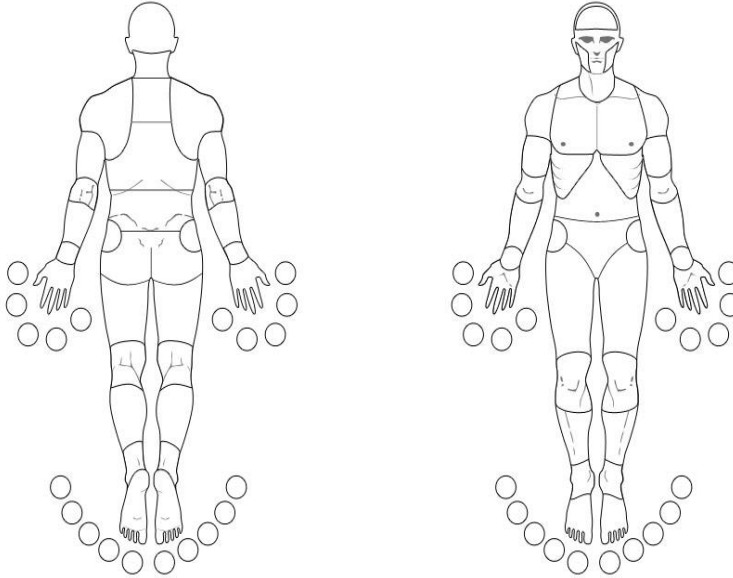


CURRENT COMPLAINTS

PATIENT'S NAME: _____

DATE: _____

Please indicate the current complaints you are experiencing by marking the image below and providing details using the sections below.



Office Use Only	
Weight	Height
BP ____/____	Pulse:
Resp:	
Right / Left Handed	
Regional Assessment	
NECK	BACK
LEFS	DASH

AREA(S) OF COMPLAINT	
Location	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center
Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Pain Ratings	<input type="checkbox"/> 0 (None) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Onset When and how did the condition begin?	
Associated with	<input type="checkbox"/> Dizziness <input type="checkbox"/> Nausea <input type="checkbox"/> Visual Problems <input type="checkbox"/> Ringing/Buzzing ears <input type="checkbox"/> Bright light <input type="checkbox"/> Sensitivity <input type="checkbox"/> Loss of balance
What makes it better?	<input type="checkbox"/> Lying Down <input type="checkbox"/> Medication <input type="checkbox"/> Nothing <input type="checkbox"/> Range of Motion <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Stretching <input type="checkbox"/> Chiropractic Tx <input type="checkbox"/> Heat <input type="checkbox"/> Ice <input type="checkbox"/> Resting
What makes it worse?	<input type="checkbox"/> Bending <input type="checkbox"/> Coughing <input type="checkbox"/> Movement <input type="checkbox"/> Prolonged Sitting <input type="checkbox"/> Prolonged Standing <input type="checkbox"/> Prolonged Lying <input type="checkbox"/> Transitioning <input type="checkbox"/> Lifting <input type="checkbox"/> Reaching
These symptoms are described as:	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing <input type="checkbox"/> Electric <input type="checkbox"/> Fiery <input type="checkbox"/> Shooting <input type="checkbox"/> Deep <input type="checkbox"/> Superficial
Would you describe the pain as radiating/shooting? If so where?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where?
When does it seem to be at its worse?	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Strenuous
Side Effects:	<input type="checkbox"/> Decreased ROM <input type="checkbox"/> Increased Sensitivity <input type="checkbox"/> Numbness <input type="checkbox"/> Stiffness <input type="checkbox"/> Tightness <input type="checkbox"/> Tingling <input type="checkbox"/> Burning <input type="checkbox"/> Spasm

Comments: _____

X

Patient's Signature