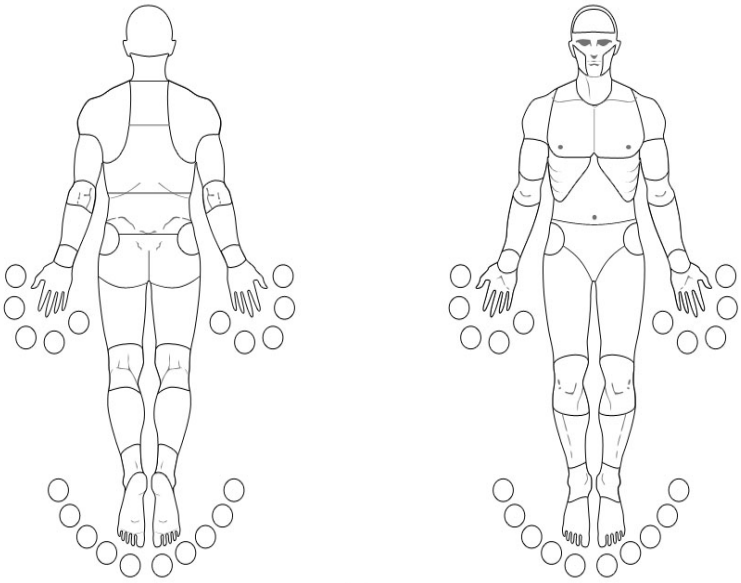
CURRENT COMPLAINTS

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

Comments:_____

_____

_____

_____

X _____

Patient's Signature