NAME _____ DATE _____

PRESENT COMPLAINTS

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE in the space below, please describe the present complaint(s) that brought you to this clinic for care. After completing this first section, please complete the questionnaire on the reverse side. The information you provide concerning past and present symptoms and diseases assists your doctor in obtaining an early understanding of your state of health.

1. Present Complaint: _____

2. Please describe the character of your pain (check all that apply): ☐ Sharp/Stabbing ☐ Sharp/ Dull ☐ Aches ☐ Dull ☐ Soreness ☐ Weakness ☐ Throbbing/ Gnawing ☐ Numbness ☐ Shooting ☐ Gripping/ Constricting ☐ Burning ☐ Tingling

3. How often are the complaints present? ☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26-50%) ☐ Intermittent (25% or less)

4. How bad is your pain or ache? 0 1 2 3 4 5 6 7 8 9 10
no pain unbearable pain

5. Since your problem began is the pain: ☐ Increasing ☐ Decreasing ☐ Not Changing

6. When did your problem began? SPECIFIC DATE IF POSSIBLE _____

7. Did your problem begin: ☐ Immediately after a specific incident ☐ Multiple incidents ☐ Gradually developed over time

8. Describe how your problem began: _____

9. What treatments have you received for this present condition? ☐ Surgery ☐ Spinal Injections ☐ Therapy from a PT ☐ Back Support ☐ If none check here ☐ Other (please specify) _____

10. Were you previously treated for a different occurrence of this same condition? ☐ Yes ☐ No If yes by: ☐ Chiropractor ☐ MD ☐ Therapist ☐ Other_____ (Specify dates & type of treatment with results) _____

11. What makes your problem better? ☐ Nothing ☐ Laying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/ Exercise ☐ Inactivity ☐ Other_____

12. What makes your problem worse? ☐ Nothing ☐ Laying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/ Exercise ☐ Inactivity ☐ Other _____

13. How would you grade your general stress level? ☐ No Stress ☐ Minimal Stress ☐ Moderate Stress ☐ Greatly Stressed

14. Physical activity at work: ☐ Sedentary more than 50% of the workday ☐ Light manual labor ☐ Manual labor ☐ Heavy manual labor

15. General physical activity: ☐ No regular physical activity ☐ Light exercise program ☐ Moderate to Strenuous exercise program

16. Are your complaints affecting your ability to work or otherwise be active? ☐ No effect ☐ Some physical restrictions (able to perform light duty work and household tasks) ☐ Need limited assistance with common everyday tasks ☐ Need assistance often ☐ Have a significant inability to function without assistance ☐ Am totally disabled (impaired). Cannot care for self.

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING