File #_____

Date _____

Patient Name:_____

Additional Complaints

Please print this page as many times as necessary.

Additional Complaint:_____

Is this condition due to an accident? YES / NO Auto ☐ Home ☐ Work ☐ Other ☐ Date_____

Are you involved in or expect litigation concerning this accident? YES / NO

When did your symptoms first appear? _____ Is this condition getting worse? YES / NO

How often do you experience this problem? _____ Is it constant or does it come and go?_____

If daily, are you aware of it 0-25%, 26-50%, 51-75%, 76-100% of the time you are awake? Circle one

Activities which are difficult or more painful to perform due to this complaint:

What treatment have you already received for your condition?

Medication(s): Prescription ☐, OTC ☐, Herbals ☐, Name:_____ Did it help? Y / N

PT ☐, Surgery ☐, Chiropractic ☐, None, ☐ Other _____ Did it help? Y / N

Other treatments ie heat, ice etc _____ Did it help? Y / N

Name of other Doctor(s) who are currently treating you for this condition:_____

What makes the complaint worse?_____

What makes the complaint improve? _____

Do you have pain, numbness, tingling etc. that go into the arms or hands, buttocks legs or feet? If so, please describe. _____

Please describe this complaint (ie burning, aching, numbness, sharp, stabbing, pins and needles etc._____

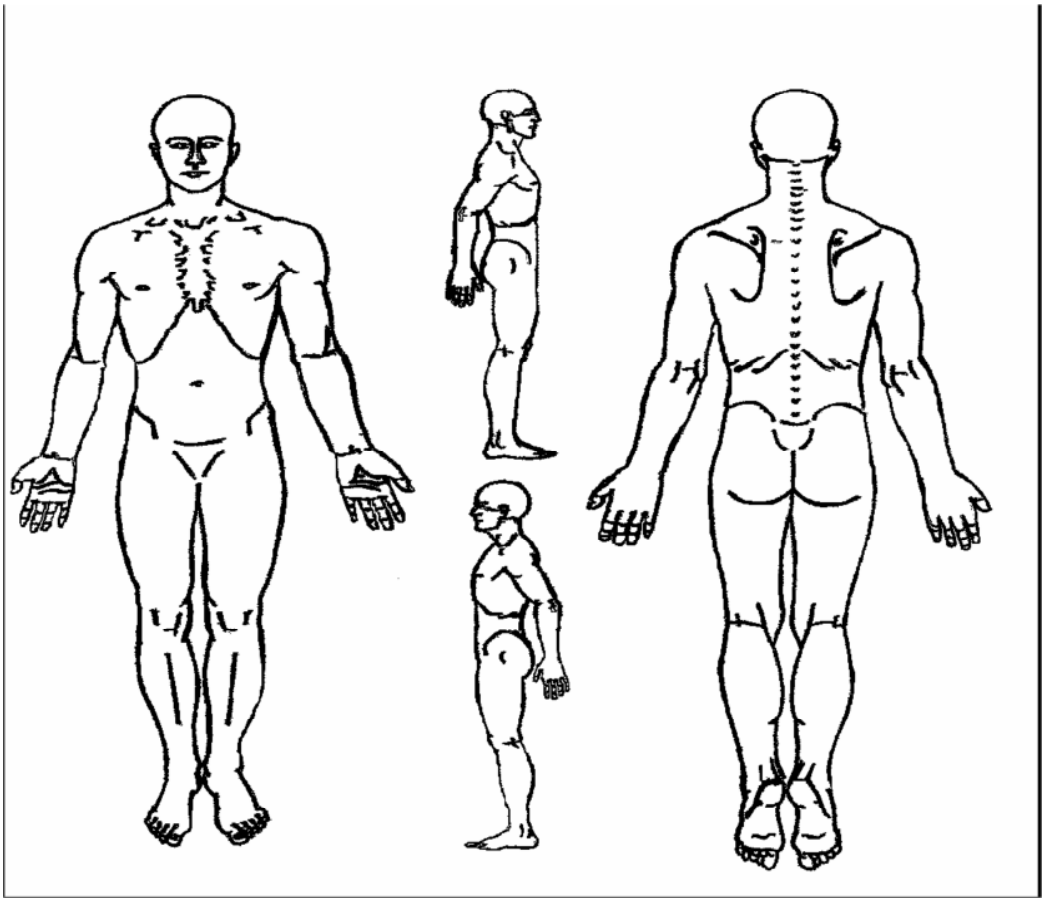
Place a mark on the scales below to describe the intensity of your pain/discomfort over the last two weeks with "0" being no pain and 10 being the worst pain imaginable.

At Rest: ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

Activity: ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

Has this pain lasted for more than three months? (please circle) Yes or No

Have you been treated for this complaint before ? Y/N If yes please explain



Does any of your pain radiate or travel from the main source down your arm or leg? Please indicate on the above diagram with arrows.