



NAME _____ ADMIT DATE _____
MONTH DAY YEAR

PRESENT COMPLAINTS

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. In the space below, please describe the present complaint(s) which 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 current pain (YOU MAY CHECK ONE OR MORE ANSWERS): 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? Please circle a number: 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 begin: SPECIFIC DATE IF POSSIBLE? _____

7. Did your problem begin: Immediately after a specific incident Multiple incidents Gradually developed over time No specific reason

8. Describe how your problem began: _____

9. What treatment have you received for this present condition? Surgery Spinal injections Therapy from a PT A back support
 Medication(s) _____ Other _____ If none check here

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 Lying Down Walking Standing Sitting Movement/Exercise Inactivity
 Other _____

12. What makes your problem worse? Nothing Lying 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

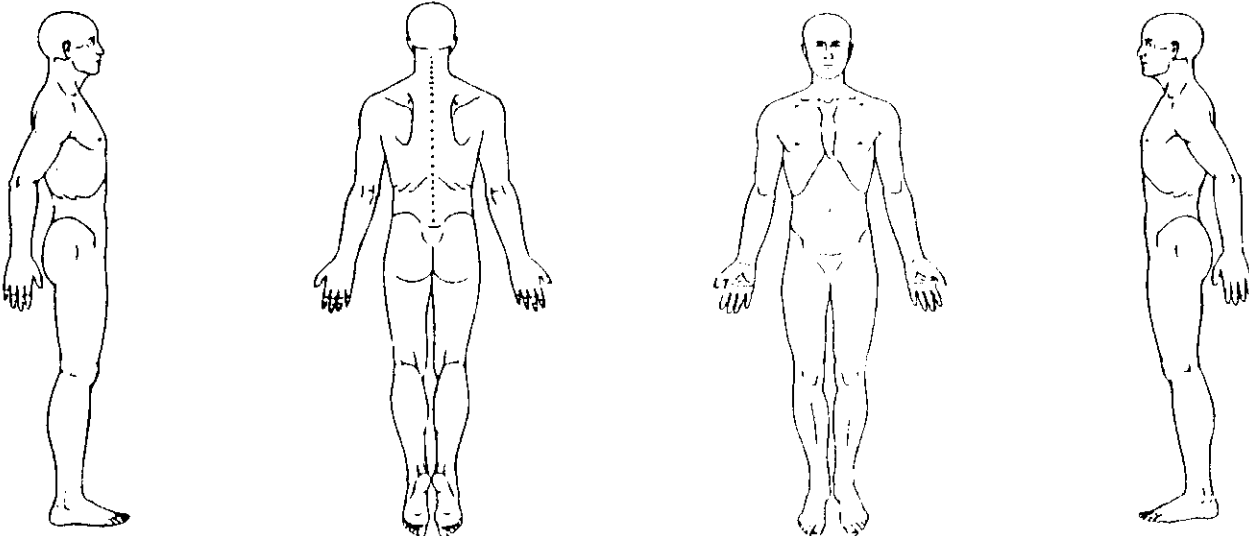
14. Physical activity at work: Sitting More Than 50% of Workday Light Manual Labor Manual Labor Heavy Manual Labor

15. General physical activity: No Regular Exercise Program Light Exercise Program Strenuous Exercise Program

16. Are your complaints affecting your ability to work or otherwise be active?

- No effect
- Need limited assistance with common everyday tasks.
- Have a significant inability to function without assistance.
- Some physical restrictions (able to perform light duty work and household tasks).
- Need assistance often.
- 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



Patient's Signature: _____ Date: _____