



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 \_\_\_\_\_

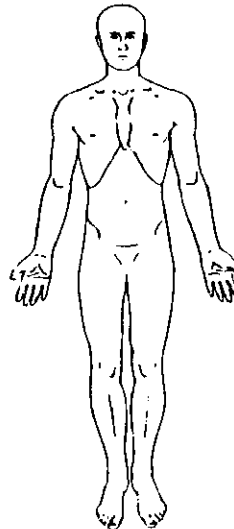
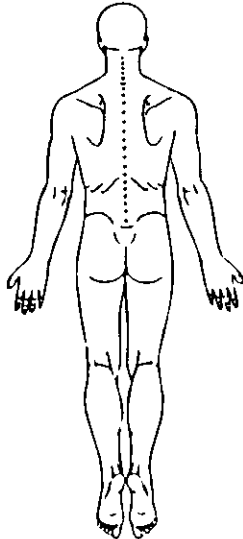
13. How would you grade your general stress level?  No Stress  Minimal Stress  Moderate Stress  Greatly Stressed

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  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



Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_