

Confidential Presenting Complaint

Name: _____ Date: _____ Chief Complaint: _____

Secondary or related complaint(s) if any: _____

Date of Onset/ When did your symptoms begin?: _____ Have you had this problem before? Yes No

Was the Onset: Gradual Sudden Since its' onset, has it gotten: Worse Better

Describe what caused the pain: _____

Have you detected any possible relationship of your current complaint with any of the following:

Muscle Weakness Bowel/Bladder problems Digestion Cardiac/Respiratory Other: _____

Have you tried any self-treatment or taken any medication (over the counter or prescription): Yes No

If yes, explain: _____ Results: _____

What medications are you currently taking?: _____

Are you currently pregnant? Yes No Are you currently taking anti-coagulant or blood thinning medication? Yes No

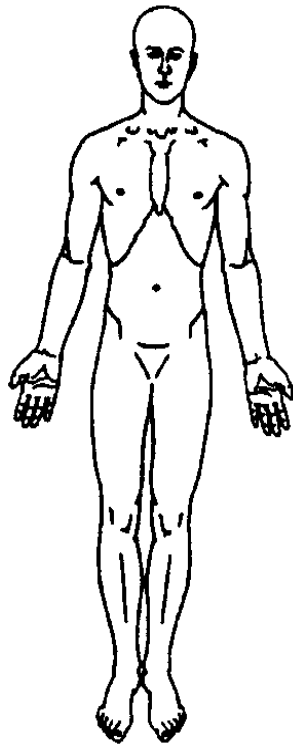
Symptom Chart

Please mark the drawing for the areas of complaint:

(S) Sharp/Stabbing pain
 (D) Dull pain
 (A) Aching
 (B) Burning
 (N) Numbness
 (T) Tingling

Severity of Pain

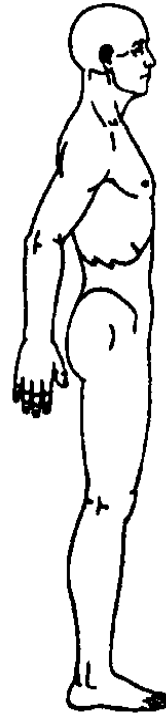
Below list region of pain and circle the number which represents the intensity of your pain.



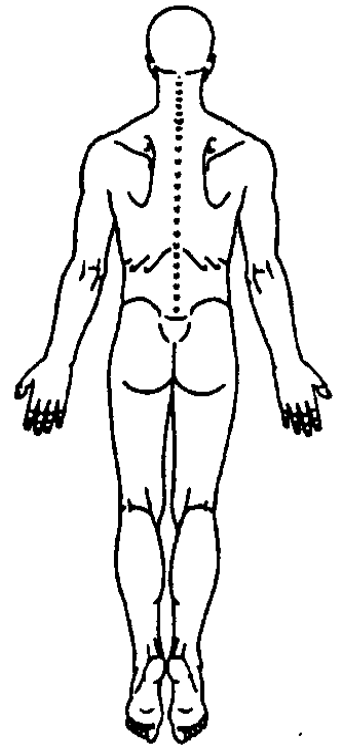
(Front)



(Left)



(Right)



(Back)

1. Complaint: _____

2. Complaint: _____

3. Complaint: _____

	(No Pain)										(Unbearable Pain)
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10