Name: _____

SUBJECTIVE COMPLAINTS

Explain **WHEN** and **HOW** it happened: _____

Complaints / Symptoms: ☐ Come and go ☐ Came on gradually ☐ Came on suddenly

Symptoms persisted for: ☐ Hours ☐ 1 Day ☐ Days ☐ Weeks ☐ Months ☐ Years

Symptoms developed from: ☐ A work-related injury ☐ An auto-accident ☐ A different type of injury

DESCRIBE COMPLAINTS: *PLEASE BE SPECIFIC*

Involving Neck & Head: _____

Involving Mid-Back / Shoulders / Arms & Hands: _____

Involving Low back / Hips / Legs & Feet: _____

PAIN LEVEL: On a scale of 0 - 10, with 0 being you're pain free and can function quite well, and 10 being you're in pain all the time and cannot function at all, where would you rate yourself?

0 1 2 3 4 5 6 7 8 9 10

No Pain Excruciating Pain

What activities make your condition *WORSE?* _____

What activities make your condition *BETTER?* _____

Have you ever had this condition/problem before? ☐ Yes ☐ No

If yes, when? _____

Give name(s) and address(es) of doctor(s) previously seen for the present complaint _____

_____

What medications are you presently taking? _____ For what condition _____

Indicate your ability to perform the following activities
Use Codes U=unable P=Painful D=Difficult
L=Limited N=Normal

____ Coughing or Sneezing
____ Getting in & out of a car
____ Bending forward to brush teeth
____ Turning over in bed
____ Walking short distances
____ Standing for more than 1 hour
____ Sitting at a table
____ Lying on back
____ Lying flat on stomach
____ Bending over forward
____ Lying on side with knees bent
____ Climbing
____ Kneeling
____ Balancing
____ Dressing self
____ Sleeping
____ Stooping
____ Gripping
____ Pushing
____ Pulling
____ Sexual Activity
____ Reaching

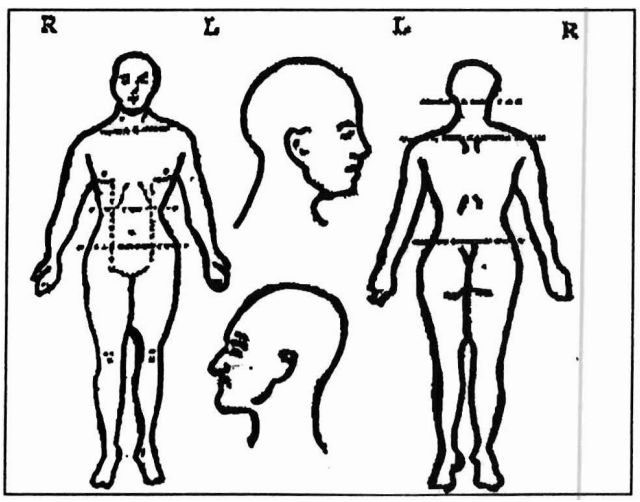
Check your Nervous stress complaints

☐ Blurring Vision
☐ Buzzing or ringing in ears
☐ Confusion
☐ Convulsions
☐ Depression or crying spells
☐ Dizziness
☐ Fainting
☐ Headaches
How often do you have headaches? _____
☐ Loss of sleep
☐ Low resistance
☐ Muscle Jerking
☐ Numbness
☐ Paralysis

Symptoms are *BETTER* in: ☐ AM ☐ Midday ☐ PM

Symptoms are worse in: ☐ AM ☐ Midday ☐ PM
Symptoms do not change with time of day ☐

Shade and code area(s) to indicate location of pain and Discomfort:
Use Codes: P = Pain N=Numbness S=Spasm T=Tenderness



(Women Only) Are you pregnant ☐ Yes ☐ No
Date of last Menstral cycle _____
Give date of last X-ray: _____

What body parts were they taken of? _____

Family history: (eg. Cancer, back problems, heart problems)
Father: Mother:
Brother/Brothers: Sister(s):