Name: _____ Date: _____

Complaint History

1. Describe your current complaint and how the problem began:_____
2. How long have you had this condition?_____
3. Were you previously treated for an earlier occurrence of this same condition? ☐ Yes ☐ No
   If yes, by whom: ☐ MD ☐ Chiropractor ☐ Physical Therapy ☐ Other:_____
4. How would you describe the pain?
   ☐ Sharp ☐ Soreness ☐ Throbbing ☐ Tingling ☐ Dull ☐ Stiffness
   ☐ Spasm ☐ Burning ☐ Ache ☐ Weakness ☐ Numbness ☐ Shooting
5. How would you rate the intensity of your pain?
   1 2 3 4 5 6 7 8 9 10
   No pain Moderate Pain Terrible/unbearable pain
6. How often is the pain present?
   ☐ Constant (81-100%) ☐ Frequent (51-80%) ☐ Occasional (26-50%) ☐ Intermittent (25% or less)
7. Since your problem began is the pain:
   ☐ Getting worse ☐ Getting better ☐ Staying the same
8. How did your problem begin?
   ☐ Auto accident ☐ Work related accident ☐ Other type of accident
   ☐ Gradual ☐ Sudden ☐ No specific reason ☐ Explain:_____
9. What makes your problem better?
   ☐ Nothing ☐ Walking ☐ Standing ☐ Sitting ☐ Moving around/Exercise ☐ Lying down ☐ Inactivity
10. What makes your problem worse?
    ☐ Nothing ☐ Walking ☐ Standing ☐ Sitting ☐ Moving around/Exercise ☐ Lying down ☐ Inactivity
11. What is your physical activity at work:
    ☐ Mostly sitting ☐ Light manual labor ☐ Moderate manual labor ☐ Heavy manual labor
12. Do you exercise?
    ☐ No regular exercise ☐ 1-2 times a week ☐ 3-4 times a week ☐ 5-7 times a week
    ☐ Cardiovascular ☐ Stretching ☐ Weight machines ☐ Free weights ☐ Sports
13. What is your present general stress level?
    ☐ No stress ☐ Minimal stress ☐ Moderate stress ☐ Greatly stressed
14. Is your problem affecting your ability to work or do other routine daily activities?
    ☐ No affect ☐ Have some limited physical restrictions, but can function
    ☐ Need some assistance with daily activities ☐ Cannot work
    ☐ Cannot function without assistance ☐ Totally disabled

15. Do you have any allergies: ☐ Latex ☐ Bee Stings ☐ Other:_____

16. Are you currently taking any medications? ☐ Yes ☐ No

If yes, please describe:

_____

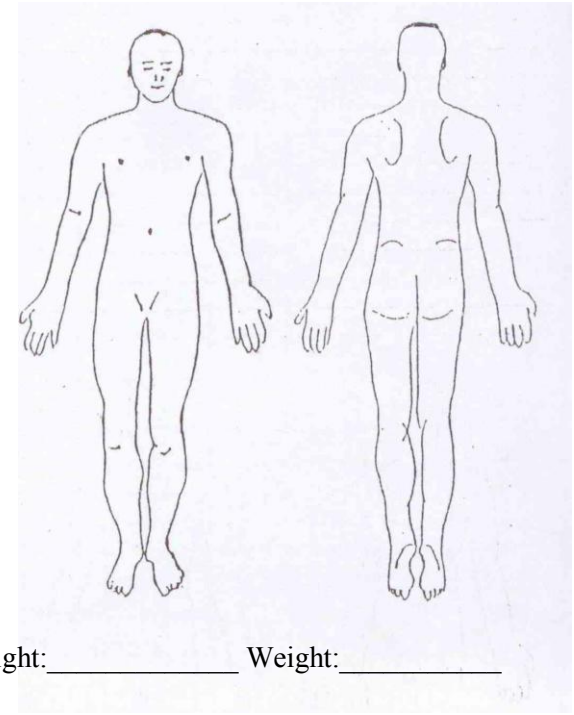
Past or Present symptoms, conditions or habits:

Please check the box indicating whether this applies to past or present

Symptom	Past	Now	Symptom	Past	Now	
Neck Pain	☐	☐	High Blood Pressure	☐	☐	Tobacco Use
Shoulder Pain	☐	☐	Heart Condition	☐	☐	☐ past ☐ present
Arm/ Elbow Pain	☐	☐	Respiratory Condition	☐	☐	☐occasional ☐ moderate ☐ heavy
Hand Pain	☐	☐	Digestive Problems	☐	☐	
Upper Back Pain	☐	☐	Kidney/Bladder Problems	☐	☐	Alcohol Use
Lower Back Pain	☐	☐	Sinus Conditions	☐	☐	☐ past ☐ present
Pain in upper leg/hip	☐	☐	Allergies Asthma	☐	☐	☐occasional ☐ moderate ☐ heavy
Pain in lower leg/hip	☐	☐	Cancer	☐	☐	
Pain in ankle or foot	☐	☐	Stroke	☐	☐	Caffeine Use
Jaw Pain	☐	☐	Excessive Weight Gain	☐	☐	☐ past ☐ present
Swelling/stiffness of joints	☐	☐	Excessive Weight Loss	☐	☐	☐occasional ☐ moderate ☐ heavy
Headaches	☐	☐	Skin Condition	☐	☐	Pregnancy
Dizziness	☐	☐	Arthritis	☐	☐	☐ past ☐ present
Fainting Spells	☐	☐	Diabetes	☐	☐	☐considering/trying
Convulsions	☐	☐	Prostate Condition	☐	☐	
Prolonged Fatigue	☐	☐	Breast soreness/lump	☐	☐	
			Uterus/Ovarian Conditions	☐	☐	

Surgical Procedure ☐ Yes ☐ No
Please List: _____

Please shade in the figures below where you have pain or other symptoms:



Height:_____ Weight:_____

Patient Name:
Patient Signature:
I have reviewed the information contained on this form with the patient
Provider's initial:
Date: