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 Therapist ☐ 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 you 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 ☐ Can not work

    ☐ Cannot function without assistance ☐ Totally disabled

Name: _____ **Date** _____

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/knee	☐	☐	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	☐	☐	
dizziness	☐	☐	arthritis	☐	☐	Pregnancy:
fainting spells	☐	☐	diabetes	☐	☐	☐ past ☐ present
convulsions	☐	☐	prostate condition	☐	☐	☐ considering/ trying
prolonged fatigue	☐	☐	breast soreness./ lump	☐	☐	
			uterus/ ovarian conditions	☐	☐	

Surgical Procedures ☐ Yes ☐ No

Please list: _____

_____

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

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