Patient Name: _____ Date_____

Present Complaint - *What brings you in the office today?*

Mark your areas of pain on the figure Below

1 ***Primary Complaint:(Where do you hurt?)***

How long have you been experiencing this primary complaint?

Describe any recently related accident or fall:

How often do you experience symptoms? (check only one)

- ☐ Constant 100% ☐ Frequent 75%
- ☐ Intermittent 50% ☐ Occasional 25%
- ☐ Daily ☐ Weekly ☐ Monthly ☐ yearly

What makes the symptoms worse?

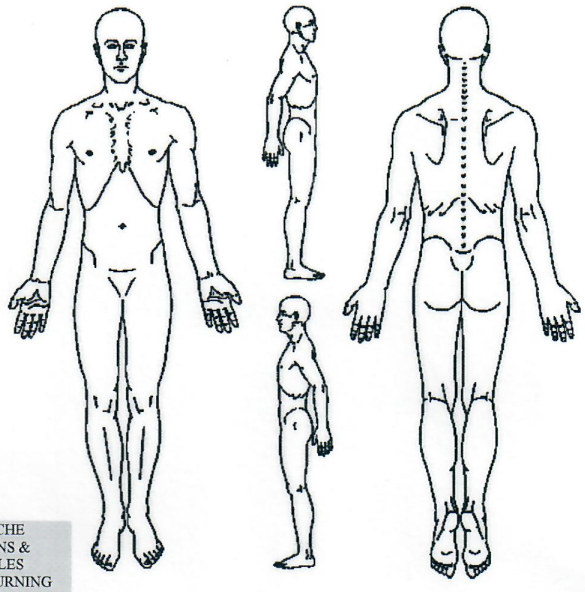
What gives relief of symptoms?

How does the primary complaint feel:

- ☐ Sharp ☐ Dull/achy ☐ Tingling ☐ Burning
- ☐ Throbbing ☐ Numbness ☐ Stabbing ☐ Cold

Where does the pain radiate to?

Does it wake you up at night? Y N



A = ACHE
P = PINS & NEEDLES
B = BURNING
S = STABBING
N = NUMBNESS
O = OTHER

Left _____ Right _____

How bad is your pain? (indicate 0 no pain - 5 pain prevents my daily activity - 10 unbearable/bed ridden)

Mild 0 ---------- 5 ---------- 10 Severe

The symptoms I experience make it difficult to:			☐ sleep	☐ carry objects	☐ move arms/legs
☐ short walk	☐ long walk	☐ twist	☐ lift	☐ bend	☐ use bathroom
☐ shower	☐ clean house	☐ do dishes	☐ vacuum	☐ enjoy life	☐ enjoy spouse

Mark your areas of pain on the figure Below

2 ***Secondary Complaint:(what else bothers you?)***

How long have you been experiencing this primary complaint?

Describe any recently related accident or fall:

How often do you experience symptoms? (check only one)

- ☐ Constant 100% ☐ Frequent 75%
- ☐ Intermittent 50% ☐ Occasional 25%
- ☐ Rare 10%

What makes the symptoms worse?

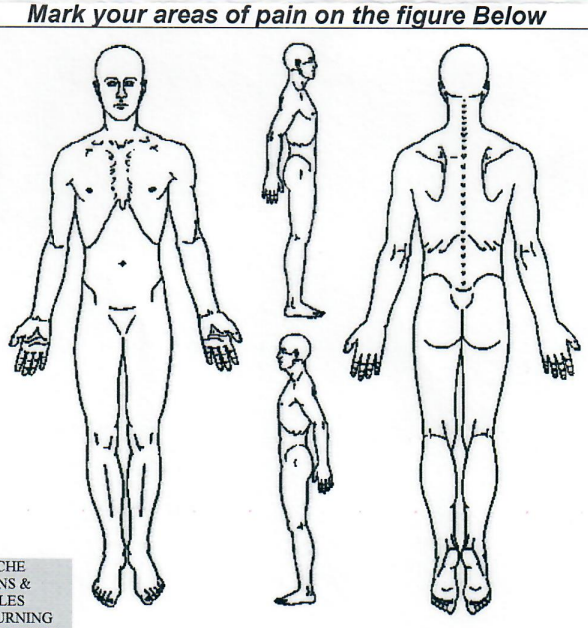
What gives relief of symptoms?

How does the secondary complaint feel:

- ☐ Sharp ☐ Dull/achy ☐ Tingling ☐ Burning
- ☐ Throbbing ☐ Numbness ☐ Stabbing ☐ Cold

Where does the pain radiate to?

Does it wake you up at night? Y N



A = ACHE
P = PINS & NEEDLES
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S = STABBING
N = NUMBNESS
O = OTHER

Left _____ Right _____

How bad is your pain? (indicate 0 no pain - 5 pain prevents my daily [illegible] 10 unbearable/bed ridden)

Mild 0 ---------- 5 ---------- 10 Severe