COMPLAINT 3 - CHECK ONLY 1 AT A TIME

☐Neck Pain ☐Headache ☐Migraine ☐ Upper/Mid Back Pain ☐Low Back Pain
☐Shoulder Pain ☐Knee Pain ☐Jaw Pain ☐Hip Pain ☐Other_____

Does the pain travel or radiate anywhere? _____

Do you know what caused the problem?
☐Fall ☐Trauma ☐Accident ☐ Bending ☐Exercise ☐Housework ☐Lifting
☐Running ☐Working ☐Sports Injury ☐Pregnancy ☐Twisting ☐Sleeping wrong ☐Standing

Frequency: How often do you feel the pain? Is it ☐ daily ☐weekly ☐ monthly

☐ 0-25% (Occasional) ☐ 26-50% (Intermittent) ☐51-75% (Frequent) ☐76-100% (Constant)

Duration: How long does the pain last when you feel symptoms?

☐Constant ☐Frequent ☐Occasional ☐Infrequent ☐other _____

Onset: When did the above symptom begin?

☐Childhood ☐Adulthood ☐Year of_____ ☐Month of_____☐Exactly this date_____

Has the condition gotten better, worse or stayed the same since its onset?

☐Better ☐Worse ☐Stayed the Same

Quality: How would you describe the pain?

☐ Aching ☐Burning ☐Cramping ☐Deep ☐ Dull ☐Numb ☐Radiating ☐Sharp
☐Shooting ☐Sore ☐Stabbing ☐Stiff ☐Swelling ☐Tight ☐Tingling ☐Throbbing

Aggravating Factors: What makes the problem worse?

☐Bending	☐Carrying things	☐Coughing	☐Driving	☐Eating
☐Exercise	☐Going down stairs	☐Heat	☐Housework	☐Ice
☐Jogging	☐Lifting	☐Lying down	☐Massage	☐Most Movements
☐Nothing	☐Pulling	☐Pushing	☐Running	☐Sitting
☐Sleeping	☐Sneezing	☐Squatting	☐Standing	☐Prolonged standing
☐Stress	☐Stretching	☐Taking a deep breath	☐Turning	☐Twisting
☐Walking	☐Working	☐Talking	☐Looking up/down	☐Breast/bottle feeding
☐Caring for children	☐ Sitting at computer	☐Sitting to Standing	☐Lying to sitting	☐Sitting to lying
☐Lying to standing	☐Bending head	☐Light	☐Allergies	☐Hormonal changes

Relieving Factors: What makes the problem better?

☐Noting ☐Anti-inflammatory ☐Bracing ☐Elevation ☐Exercise ☐Heat ☐Ice ☐Standing
☐Rest ☐Chiropractic Care ☐Massage ☐Movement ☐Pain Killers ☐Stretching ☐Walking ☐Sitting ☐CBD oil

What activities of daily living are affected (or difficult) due to the problem?

☐Bathing	☐Caring for children	☐Climbing stairs	☐Dressing	☐Yard work	☐Social activities
☐Driving	☐Eating	☐Exercising	☐Sitting to standing	☐Grooming	☐Housework
☐Lifting	☐Lying to sitting	☐Oral Care	☐Shopping	☐Sitting	☐Sleeping
☐Standing	☐Stretching	☐Using technology	☐Walking	☐Watching TV	☐Working

On a scale of 1-10 (10 the worst pain you can imagine), what would you rate your pain TODAY

0 1 2 3 4 5 6 7 8 9 10

COMPLAINT 4 - CHECK ONLY 1 AT A TIME

☐Neck Pain ☐Headache ☐Migraine ☐ Upper/Mid Back Pain ☐Low Back Pain
☐Shoulder Pain ☐Knee Pain ☐Jaw Pain ☐Hip Pain ☐Other_____

Does the pain travel or radiate anywhere? _____

Do you know what caused the problem?
☐Fall ☐Trauma ☐Accident ☐ Bending ☐Exercise ☐Housework ☐Lifting
☐Running ☐Working ☐Sports Injury ☐Pregnancy ☐Twisting ☐Sleeping wrong ☐Standing

Frequency: How often do you feel the pain? Is it ☐ daily ☐weekly ☐ monthly

☐ 0-25% (Occasional) ☐ 26-50% (Intermittent) ☐51-75% (Frequent) ☐76-100% (Constant)

Duration: How long does the pain last when you feel symptoms?

☐Constant ☐Frequent ☐Occasional ☐Infrequent ☐other _____

Onset: When did the above symptom begin?

☐Childhood ☐Adulthood ☐Year of_____ ☐Month of_____☐Exactly this date_____

Has the condition gotten better, worse or stayed the same since its onset?

☐Better ☐Worse ☐Stayed the Same

Quality: How would you describe the pain?

☐ Aching ☐Burning ☐Cramping ☐Deep ☐ Dull ☐Numb ☐Radiating ☐Sharp
☐Shooting ☐Sore ☐Stabbing ☐Stiff ☐Swelling ☐Tight ☐Tingling ☐Throbbing

Aggravating Factors: What makes the problem worse?

☐Bending	☐Carrying things	☐Coughing	☐Driving	☐Eating
☐Exercise	☐Going down stairs	☐Heat	☐Housework	☐Ice
☐Jogging	☐Lifting	☐Lying down	☐Massage	☐Most Movements
☐Nothing	☐Pulling	☐Pushing	☐Running	☐Sitting
☐Sleeping	☐Sneezing	☐Squatting	☐Standing	☐Prolonged standing
☐Stress	☐Stretching	☐Taking a deep breath	☐Turning	☐Twisting
☐Walking	☐Working	☐Talking	☐Looking up/down	☐Breast/bottle feeding
☐Caring for children	☐ Sitting at computer	☐Sitting to Standing	☐Lying to sitting	☐Sitting to lying
☐Lying to standing	☐Bending head	☐Light	☐Allergies	☐Hormonal changes

Relieving Factors: What makes the problem better?

☐Noting ☐Anti-inflammatory ☐Bracing ☐Elevation ☐Exercise ☐Heat ☐Ice ☐Standing
☐Rest ☐Chiropractic Care ☐Massage ☐Movement ☐Pain Killers ☐Stretching ☐Walking ☐Sitting ☐CBD oil

What activities of daily living are affected (or difficult) due to the problem?

☐Bathing	☐Caring for children	☐Climbing stairs	☐Dressing	☐Yard work	☐Social activities
☐Driving	☐Eating	☐Exercising	☐Sitting to standing	☐Grooming	☐Housework
☐Lifting	☐Lying to sitting	☐Oral Care	☐Shopping	☐Sitting	☐Sleeping
☐Standing	☐Stretching	☐Using technology	☐Walking	☐Watching TV	☐Working

On a scale of 1-10 (10 the worst pain you can imagine), what would you rate your pain TODAY

0 1 2 3 4 5 6 7 8 9 10

Any changes in your medications?_____

IF YOU HAVE MORE CURRENT COMPLAINTS, PLEASE ASK FOR AN ADDITIONAL FORM

WHEN COMPLETE, PLEASE RETURN TO THE FRONT DESK. THANK YOU!