COMPLAINT 3 - CHECK ONLY 1 AT A TIME (there is additional space for more complaints on next page)

☐Neck Pain ☐Headache ☐Migraine ☐ Upper Back Pain ☐Mid Back Pain
☐Low Back Pain ☐Shoulder (L R) ☐Knee (L R) ☐Jaw Pain ☐Hip Pain (L R)
☐Foot/Ankle (L R) ☐Wrist/Hand (L R) ☐Other________

Does the pain travel or radiate anywhere? ____

Do you know what caused the problem or what you were doing at the time of injury/start of pain?

☐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 ☐Prolonged 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
☐Clenching teeth ☐Grinding teeth ☐Dehydration ☐Lack of Sleep ☐Reading/eye strain
☐Electronic use ☐Caffeine intake ☐Strong Scents ☐Noise ☐Weather Changes

Relieving Factors: What makes the problem better?

☐Nothing ☐Anti-inflammatory ☐Bracing ☐Elevation ☐Exercise ☐Heat ☐Ice
☐Standing ☐Rest ☐Chiropractic Care ☐Massage ☐Movement ☐Pain Killers
☐Stretching ☐Walking ☐Sitting ☐CBD

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
☐Cleaning ☐Cooking ☐Doing Laundry ☐Laying Down ☐Sex ☐Toileting
☐School Work

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 - <u>CHECK ONLY 1 AT A TIME</u>

☐Neck Pain ☐Headache ☐Migraine ☐ Upper Back Pain ☐Mid Back Pain
☐Low Back Pain ☐Shoulder (L R) ☐Knee (L R) ☐Jaw Pain ☐Hip Pain (L R)
☐Foot/Ankle (L R) ☐Wrist/Hand (L R) ☐Other________

Does the pain travel or radiate anywhere? ______________________________

Do you know what caused the problem or what you were doing at the time of injury/start of pain?

☐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 ☐Prolonged 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
☐Clenching teeth ☐Grinding teeth ☐Dehydration ☐Lack of Sleep ☐Reading/eye strain
☐Electronic use ☐Caffeine intake ☐Strong Scents ☐Noise ☐Weather Changes

Relieving Factors: What makes the problem better?

☐Nothing ☐Anti-inflammatory ☐Bracing ☐Elevation ☐Exercise ☐Heat ☐Ice
☐Standing ☐Rest ☐Chiropractic Care ☐Massage ☐Movement ☐Pain Killers
☐Stretching ☐Walking ☐Sitting ☐CBD

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
☐Cleaning ☐Cooking ☐Doing Laundry ☐Laying Down ☐Sex ☐Toileting
☐School Work

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

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