

Updated Subjective Complaints

Name _____ Today's Date ____ / ____ / ____

Address: _____

Email: _____ Phone: _____

Current Complaints:

Head and Neck: _____

Mid-Back, Shoulders, Arms and Hands: _____

Low-Back, Hips, Legs and Feet: _____

How have your symptoms changed: Increasing Decreasing Not Changing (Please circle one)

Is the pain: ___Stabbing ___Sharp ___Dull ___Aches/Sore ___Throbbing ___Numbness ___Burning ___Tingling ___Other: _____

Is the pain: Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (25% or less)

How bad is your pain or ache? (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

Check your nervous system complaints:

- | | | |
|---|--|--|
| <input type="checkbox"/> Loss of Energy | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of memory |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Ringing/Buzzing in ears |
| <input type="checkbox"/> Crying Spells | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Other: _____ |

Describe any accidents/injuries/diseases since your last visit and when they occurred:

What makes it better? _____

What makes it worse? _____

Indicate ability to perform the following activities: U=unable, P=painful, D=difficult, L=limited, N=normal

- | | | |
|------------------------------------|-----------------------------------|-----------------------------------|
| ___ Coughing | ___ Walking long distances | ___ Lying flat on stomach |
| ___ Climbing | ___ Sleeping | ___ Pulling |
| ___ Getting in/out of car | ___ Standing for more than 1 hour | ___ Lying on side with knees bent |
| ___ Kneeling | ___ Stooping | ___ Reaching |
| ___ Bending forward to brush teeth | ___ Sitting for more than 1 hour | ___ Bending forward |
| ___ Balancing | ___ Gripping | ___ Sexual activity |
| ___ Turning over in bed | ___ Lying on back | ___ Other: _____ |
| ___ Dressing self | ___ Pushing | |

Symptoms are better in: am midday pm

Symptoms are worse in: am midday pm

Symptoms do not change with time of day

How do you classify your improvements so far?

- Excellent Good Okay Poor No improvement

Have you tried to refer anyone for chiropractic care? Yes No

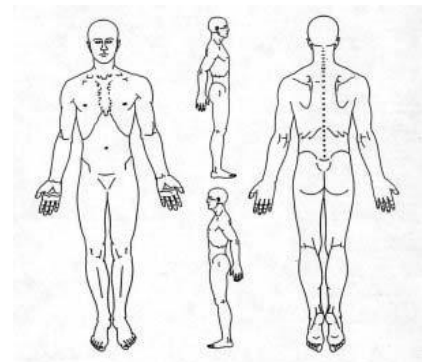
Would you be willing to be our Patient of the month? Yes No

Your cooperation in providing us with accurate information on this form will enable us to provide quality chiropractic health care.

Signature _____

Date ____ / ____ / ____

Symptom Location



Please outline the area of pain on the diagram above

Doctor's Use