EXISTING COMPLAINT

NAME: _____ DOB: _____ DATE: _____

PLEASE ANSWER THE FOLLOWING SO THAT WE CAN BETTER ASSIST YOU WITH YOUR CARE AND TO BETTER DOCUMENT YOUR NEED FOR CHIROPRACTIC CARE.

Area of pain: **N** = neck **M** = mid back **L** = lower back **S** = right/left sacroiliac **T** = tailbone

Check what applies:

( ) Neck pain ( ) Neck spasm ( ) Neck stiffness
( ) Neck tension, Other _____
( ) Mid back pain ( ) Mid back spasm ( ) Rib pain
( ) Lower back pain ( ) Lower back spasm ( ) Lower back stiffness
( ) Sacroiliac joint pain: ( ) Right side ( ) Left side

Circle area(s) of Complaint:	Pain Scale - Circle degree of discomfort									
	No Pain	Mild			Moderate			Severe		
NECK:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
Pain										
Spasm										
Stiffness										
Tension										
MID BACK:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
Pain										
Spasm										
Rib pain										
LOWER BACK:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
Pain										
Spasm										
Stiffness										
SACROILIAC JOINT:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
Pain - Right Side										
Pain - Left Side										
TAILBONE:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**

Have you taken pain medication for your pain prior to your visit today? YES _____ NO_____

Has this affected your pain scale now? YES_____ NO_____

If so, what was your pain scale before the medication? List the number: _____.

Have you had an incident or exacerbation of your condition since your last visit? If so, please ask for either the *"OUCH"* form or the *"Accident"* form.

Please describe any areas of pain that is not covered in this form: _____

_____

_____

_____

COMPLETE SIDE TWO ALSO

N = neck **M** = mid back **L** = lower back **S** = right/left sacroiliac **T** = tailbone

Circle the letter which corresponds to each area of your body affected by the following symptoms:

Frequency

Intermittent (occurs less than 25% of time)	**N**	**M**	**L**	**S**	**T**
Occasional (occurs between 25% and 50% of time)	**N**	**M**	**L**	**S**	**T**
Frequent (occurs between 50% and 75% of time)	**N**	**M**	**L**	**S**	**T**
Constant (occurs between 75% and 100%of time)	**N**	**M**	**L**	**S**	**T**

Overall Severity (Circle what applies)

Mild - **N M L S T**	Mild to Moderate - **N M L S T**	Severe - **N M L S T**		
Moderate - **N M L S T**	Moderately Severe - **N M L S T**			

Circle the letter which corresponds to each area of your body affected by the following symptoms:

Movement:	Inflexibility	**N M L S T**	Restricted Movement	**N M L S T**	Stiffness	**N M L S T**
Sensations:	Crawling	**N M L S T**	Pins & Needles	**N M L S T**	Tingling	**N M L S T**
Pain Type:	Pounding	**N M L S T**	Electric Shock	**N M L S T**	Tight	**N M L S T**
	Pulsating	**N M L S T**	Excruciating	**N M L S T**	Achy	**N M L S T**
	Stiffness	**N M L S T**	Numb-ache type	**N M L S T**	Dull	**N M L S T**
	Stabbing	**N M L S T**	Throbbing	**N M L S T**	Sharp	**N M L S T**
	Shooting	**N M L S T**	Burning	**N M L S T**	Stinging	**N M L S T**
	Sore	**N M L S T**	Other			

Area:

The pain is local _____

It migrates to _____

It radiates to _____

Is shooting into _____

What makes your pain(s) worse:

Circle the letter which corresponds to each area of your body affected by the following symptoms:

Turning head right	**N M L S T**	Looking down	**N M L S T**	Sitting	**N M L S T**
Turning head left	**N M L S T**	Looking up	**N M L S T**	Lifting	**N M L S T**
Getting out of bed	**N M L S T**	Standing	**N M L S T**	Raking	**N M L S T**
Getting out of car	**N M L S T**	Coughing	**N M L S T**	Bending	**N M L S T**
Emotional upset	**N M L S T**	Sneezing	**N M L S T**	Stress	**N M L S T**
Climbing stairs	**N M L S T**	Walking	**N M L S T**	Anger	**N M L S T**
Shoveling snow	**N M L S T**	Pushing	**N M L S T**		
Stooping	**N M L S T**	Pulling	**N M L S T**		

Other _____

What makes your pain(s) worse:

Circle the letter which corresponds to each area of your body affected by the following symptoms:

Trigger Point Therapy	**N M L S T**	Bending	**N M L S T**	Tub soaking	**N M L S T**
Chiropractic adjustment	**N M L S T**	Reclining	**N M L S T**	Liniment	**N M L S T**
Prescription medication	**N M L S T**	Sleeping	**N M L S T**	Ice	**N M L S T**
Stretching	**N M L S T**	Sitting	**N M L S T**	Heat	**N M L S T**
Exercising	**N M L S T**	Nothing	**N M L S T**	Massage	**N M L S T**
Walking	**N M L S T**	Resting	**N M L S T**	Over the counter medication	**N M L S T**

Other _____

Sign _____ **Date** _____