

Name: _____
 Address: _____
 City/ST/Zip: _____
 INDICATE IF THERE HAS BEEN AN EMPLOYMENT CHANGE:
 Employer's Name: _____
 Address: _____
 City/ST/Zip: _____

Date: _____ File #: _____
 Phone: Home: _____ Work: _____
 INDICATE ANY CHANGE IN INSURANCE STATUS:
 Insurance Company: _____
 Address: _____
 City/ST/Zip: _____
 Name of Insured (if other than patient): _____

PRESENT COMPLAINTS

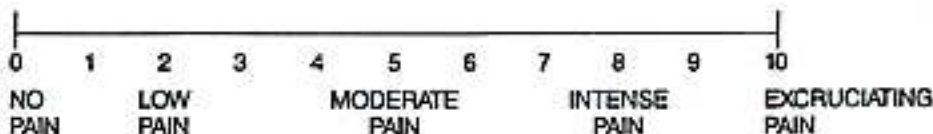
10 HEADACHE NECK Pain Spasm Tender Sore Ache Stiff Shooting Weak
Numb Other _____ How has your condition changed since your last exam? Less pain
Same pain More pain No pain Increased motion Same motion Decreased motion

20 MIDBACK SHOULDERS ARMS HANDS Pain Spasm Tender Sore Ache
Stiff Shooting Weak Numb Other: _____ How has your condition changed since
 your last exam? Less pain Same pain More pain No pain Increased motion Same motion
Decreased motion Other: _____

30 LOW BACK HIPS LEGS FEET Pain Spasm Tender Sore Ache Stiff
Shooting Weak Numb Other: _____ How has your condition changed since your last
 exam? Less pain Same pain More pain No pain Increased motion Same motion
Decreased motion Other: _____

40 **CHECK YOUR NERVOUS SYSTEM COMPLAINTS:** Blurred vision Buzzing/ringing in ears Confusion
Convulsions Depression/crying spells Dizziness Fainting Paralysis Headaches How often
 do you have headaches? _____ Loss of sleep Low resistance Muscle jerking Numbness

50 **PAIN LEVEL:** On a scale of 0-10, with 0
 being you're pain free and can function
 quite well, and 10 being you're in
 excruciating pain all the time, where
 would you rate the intensity of your pain?



60 Describe any accident/injuries/diseases since your last visit—when? _____

70 What makes your condition worse? Nothing Lifting Trying to stand Standing Walking Sitting
Movement Exercise Inactivity Work activities Home activities Other: _____

80 What makes your condition better? Nothing Standing Walking Sitting Movement Exercise
Inactivity Lying down Sleep Hot shower/bath Stretching Other: _____

90- **ABILITY TO PERFORM THE FOLLOWING ACTIVITIES:**

120 **CODES:** U=Unable/90 P=Painful/100 D=Difficult/110
 L=Limited/110 N=Normal/120

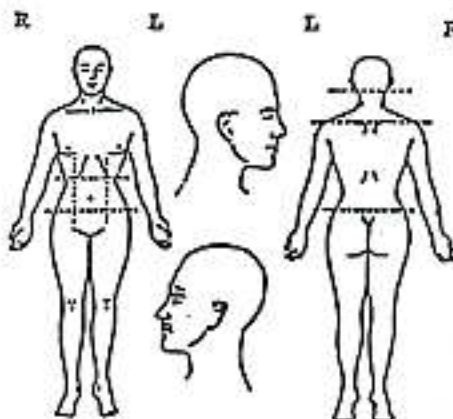
- | | |
|--|--|
| <input type="checkbox"/> Coughing or sneezing | <input type="checkbox"/> Climbing |
| <input type="checkbox"/> Getting in or out of a car | <input type="checkbox"/> Kneeling |
| <input type="checkbox"/> Bending over forward | <input type="checkbox"/> Balancing |
| <input type="checkbox"/> Putting on clothes | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Putting on shoes | <input type="checkbox"/> Looking back |
| <input type="checkbox"/> Turning over in bed | <input type="checkbox"/> Sleeping |
| <input type="checkbox"/> Getting out of bed | <input type="checkbox"/> Stooping |
| <input type="checkbox"/> Standing for more than 10 minutes | <input type="checkbox"/> Gripping |
| <input type="checkbox"/> Standing for more than 60 minutes | <input type="checkbox"/> Pushing |
| <input type="checkbox"/> Walking short distances | <input type="checkbox"/> Pulling |
| <input type="checkbox"/> Lying flat on stomach | <input type="checkbox"/> Reaching |
| <input type="checkbox"/> Lying on side with knees bent | <input type="checkbox"/> Sexual Activity |

160 Rate your satisfaction with the treatment received?

Very pleased Pleased Not pleased

170 **SHADE AND CODE AREA(S) OF COMPLAINT:**

USE CODES: P=Pain N=Numb S=Spasm



130 Symptoms are **BETTER** in: AM Midday PM

140 Symptoms are **WORSE** in: AM Midday PM

150 Symptoms do not change with time of day _____