ESTABLISHED PATIENT COMPLAINT REGION/S

Date______________ **Patient Name:**____ Date of Birth: _______________
Mailing Address:____
Home Phone #:_________________________ **Cell Phone #:**____________________ **Work Phone #:**___________________
Insurance Name:____ Is Your Insurance an HMO-Type? ___Yes ___ NO
Name of Primary Health Care Provider________________________________ Occupation:__________________________

PLEASE COMPLETELY FILL IN THE INFORMATION ABOVE

Please list in the box below all your areas of complaints, **rating your "pain" on a scale or range of 0 to 10** with "0" meaning **no pain** and "10" the **worst pain.** To indicate what side of the body mark, "R" for right side, "L" for left side, "C " for center and "B" for both sides. (See Sample Sheet Attached)

Area/s of Pain or Discomfort/ as per patient	Rate Your Level of Pain Here	NUMBNESS	TINGLING	STIFFNESS	SORENESS	WEAKNESS	MILD	MODERATE	SEVERE	BURNING	DULL	Sharp-Shooting	ACHING	THROBBING	OCCASIONAL	INTERMITTENT	FREQUENT	CONSTANT	IMPROVING	WORSENING	UNCHANGED	RESOLVED	**FOR OFFICE USE ONLY** PATIENT INFORMATION RELATED TO HISTORY OF COMPLAINT REGIONS:
Sample: NECK	3-8			C	C			C		C		R	C					C		C			
Headache																							
Jaw/TMJ																							
Neck																							
Shoulder																							
Entire Arm																							
Forearm																							
Wrist/Hand																							
Upper Back																							
Mid Back																							
Lower Back																							
Buttock																							
Groin																							
Hip																							
Entire Leg																							
Thigh																							
Knee																							
Calf																							
Ankle/Foot																							
Front Ribs																							
Other______																							

List DATE your **symptoms** Began or Returned again?_____________ What **caused** your condition?____________________

Please list any other illnesses, new diseases or injuries since last visit to this office:
diseases,:____
List all treatments you have received for your complaints:
____

Has your complaint come on (Circle): Suddenly Gradually Comes & Goes
Is your complaint/s **caused** from: Auto Accident (**Y**) (**N**) – Job Injury (**Y**) (**N**)?
Has it created any change in bladder, bowel or sexual function? ( ) **Yes** ( ) **No**

~Currently your symptoms are aggravated by (Please Circle):

Coughing	Sneezing	Straining at Stool	Head feels heavy
Bending	Reaching	Neck movement	Lying down on your side
Sitting/Arising	Walking	Standing	Lying down on your back
Lifting	Reclining	Turning over in bed	Other/s______________

~Currently your symptoms are relieved by(Please Circle):

Nothing	Walking	Stretching	Lying down
Sitting	Standing	Rest	Over the counter pain meds
Heat	Exercise	Reclining	Prescription medication
Massage	Ice	Other/s_______________________	

Patient: Please circle the areas causing you discomfort or pain on the drawing below.

Patient Signature___________________________________ **Date** _________________

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