Complaint #2 Information:

What is the purpose of your visit? _____ What is the reason for this visit? _____

What caused this condition? _____ When did this condition begin? _____

How long have you had this condition? _____

Where is the discomfort? Choose all that apply.

Head: ☐ Front of head ☐ Back of head ☐ Right side of head ☐ Left side of head

Neck: ☐ Front of neck ☐ Back of neck ☐ Right side of neck ☐ Left side of neck

Back: ☐ Right mid back ☐ Left mid back ☐ Central mid back ☐ Right low back ☐ Left low back ☐ Central low back

Trunk: ☐ Abdomen ☐ Chest ☐ Front of ribs ☐ Back of ribs ☐ Right side of ribs ☐ Left side of ribs

Upper Extremity:	☐ Front of right upper extremity	☐ Rear of right upper extremity	☐ Front of left lower extremity	☐ Rear of left lower extremity
	☐ Front of right shoulder	☐ Rear of right shoulder	☐ Front of left shoulder	☐ Rear of left shoulder
	☐ Front of right upper arm	☐ Rear of right upper arm	☐ Front of left upper arm	☐ Rear of left upper arm
	☐ Front of right elbow	☐ Rear of right elbow	☐ Front of left elbow	☐ Rear of left elbow
	☐ Front of right wrist	☐ Rear of right wrist	☐ Front of left wrist	☐ Rear of left wrist
	☐ Front of right hand	☐ Rear of right hand	☐ Front of left hand	☐ Rear of left hand
Lower Extremity	☐ Front of right lower extremity	☐ Rear of right lower extremity	☐ Front of left lower extremity	☐ Rear of left lower extremity
	☐ Front of right hip	☐ Rear of right hip	☐ Front of left hip	☐ Rear of left hip
	☐ Front of right thigh	☐ Rear of right thigh	☐ Front of left thigh	☐ Rear of left thigh
	☐ Front of right knee	☐ Rear of right knee	☐ Front of left knee	☐ Rear of left knee
	☐ Front of right leg	☐ Rear of right leg	☐ Front of left leg	☐ Rear of left leg
	☐ Front of right ankle	☐ Rear of right ankle	☐ Front of left ankle	☐ Rear of left ankle
	☐ Top of right foot	☐ Bottom of right foot	☐ Right side of right foot	☐ Left side of right foot
	☐ Top of left foot	☐ Bottom of left foot	☐ Right side of left foot	☐ Left side of left foot
	☐ OTHER			

Does the discomfort radiate/travel? ○ Yes ○ No

Where does the pain radiate to? Choose all that apply; choose non-radiating if none apply.

☐ Non-radiating			
☐ Front of left chest	☐ Front of right chest	☐ Front of left abdomen/groin	☐ Front of right abdomen/groin
☐ Front of left thigh	☐ Front of left lower leg	☐ Radiating to top of left foot	☐ Front of left shoulder
☐ Front of left upper arm	☐ Front of left lower arm	☐ Front of left hand	☐ Front of left face
☐ Front of right thigh	☐ Front of right lower leg	☐ Radiating to top of right foot	☐ Front of right shoulder
☐ Front of right upper arm	☐ Front of right lower arm	☐ Front of right hand	☐ Front of right face
☐ Back of left thigh	☐ Back of left lower leg	☐ Bottom of left foot	☐ Back of left shoulder
☐ Back of left upper arm	☐ Back of left lower arm	☐ Back of left hand	☐ Back of left side of head
☐ Back of right thigh	☐ Back of right lower leg	☐ Bottom of right foot	☐ Back of right shoulder
☐ Back of right upper arm	☐ Back of right lower arm	☐ Back of right hand	☐ Back of right side of head

Describe the quality of the discomfort. Choose all that apply.

☐ Aching	☐ Annoying	☐ Burning	☐ Deep	☐ Diffuse	☐ Dull
☐ Heavy	☐ Intolerable	☐ Pulling	☐ Sharp	☐ Shock-like	☐ Shooting
☐ Stabbing	☐ Stiffness	☐ Throbbing	☐ Tightness	☐ Tingling	☐ OTHER

Complaint #2 Information (2):

Onset of discomfort: ○ Gradual ○ Insidious ○ Recent ○ Spontaneous ○ Sudden ○ Traumatic ○ Unknown

Intensity of discomfort: ○ Mild ○ Mild to moderate ○ Moderate ○ Moderate to severe ○ Severe

Severity of discomfort: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Frequency of discomfort: ○ Constant ○ Frequent ○ Intermittent ○ On and off ○ Random ○ Recurring

How has severity of the complaint changed since the onset? ○ Improved ○ Stayed the same ○ Worsened

What activity is most significantly affected by this discomfort? _____

What improves this condition? Choose all that apply.

☐ Chiropractic adjustment ☐ Cold packs ☐ Exercise ☐ Heat packs ☐ Massage
☐ Nothing ☐ OTC medications ☐ Physical therapy ☐ Prescription medication ☐ Re-direct attention
☐ Rest ☐ Stretching ☐ Work ☐ OTHER

What treatment have you received for this condition up to now?

☐ None ☐ Acupuncture ☐ Chiropractic care ☐ Craniosacral therapy ☐ Homeopathic medicine
☐ Hypnosis ☐ Injection therapy ☐ Medical care ☐ Naturopathic medicine ☐ Nutritional supplements
☐ Occupational therapy ☐ Osteopathic medicine ☐ OTC medications ☐ Physical therapy ☐ Prescribed medications
☐ Psychotherapy ☐ Reiki ☐ Surgery ☐ OTHER

Were any diagnostic tests performed to assess this condition (including X-rays, MRIs, etc.)? ○ Yes ○ No ○ Unsure

Have you ever had any previous episodes of this condition? ○ Yes ○ No

In what ways does this condition affect your life and your ability to function? Choose all that apply.

☐ Bending over ☐ Caring for family ☐ Climbing stairs ☐ Concentrating ☐ Dressing myself
☐ Driving a car ☐ Exercising ☐ Getting in/out of car ☐ Getting to sleep ☐ Grocery shopping
☐ Household chores ☐ Lifting objects ☐ Looking over shoulder ☐ Love life ☐ Lying down
☐ Reaching overhead ☐ Rising out of chair or bed ☐ Showering or bathing ☐ Sitting ☐ Standing
☐ Staying asleep ☐ Using a computer ☐ Walking ☐ Yardwork

Do you have an additional complaint? ○ Yes ○ No

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