PATIENT COMPLAINTS

Patient Name: _____ Date: _____

PLEASE FILL OUT ONLY THE ITEMS THAT APPLY TO YOUR PAIN

	Frequency	Intensity	Pain type
A) GENERAL	Const / Intermit	Mild/Moderate/Severe	Sharp/Dull
Anxiety	1 2	1 2 3	
Cannot concentrate	1 2	1 2 3	
Nervousness	1 2	1 2 3	
Irritability	1 2	1 2 3	
Fatigue	1 2	1 2 3	
Depression	1 2	1 2 3	
Memory loss	1 2	1 2 3	
Loss of sleep	1 2	1 2 3	
Tension	1 2	1 2 3	
Fainting spells	1 2	1 2 3	
Dizzy spells	1 2	1 2 3	
PMS	1 2	1 2 3	
Menopause	1 2	1 2 3	
B) HEAD	Const / Intermit	Mild/Moderate/Severe	Sharp/Dull
Headache	1 2	1 2 3	1 2
Jaw pain	1 2	1 2 3	1 2
Jaw tension	1 2	1 2 3	
Pain in ears Lt.	1 2	1 2 3	1 2
Rt.	1 2	1 2 3	1 2
Ringing in ears Lt.	1 2	1 2 3	
Rt.	1 2	1 2 3	
Ear discharge Lt.	1 2	1 2 3	
Rt.	1 2	1 2 3	
Hearing loss Lt.		1 2 3	
Rt.		1 2 3	
Eye pain Lt.	1 2	1 2 3	1 2
Rt.	1 2	1 2 3	1 2
Decreased acuity	1 2	1 2 3	
Light sensitivity	1 2	1 2 3	
Floating lights	1 2	1 2 3	
Nose bleeds	1 2	1 2 3	
Nasal obstruction	1 2	1 2 3	
C) NECK/THROAT	Const / Intermit	Mild/Moderate/Severe	Sharp/Dull
Neck pain Lt.	1 2	1 2 3	1 2
Diffuse	1 2	1 2 3	1 2
Rt.	1 2	1 2 3	1 2
Pain radiates to Lt.	Shldr____ Arm____ Elbow____ Wrist____ Fingers____		
Rt.	Shldr____ Arm____ Elbow____ Wrist____ Fingers____		
Stiffness	1 2	1 2 3	
Grinding sounds	1 2	1 2 3	
Popping sounds	1 2	1 2 3	
Hoarseness	1 2	1 2 3	
D) SHOULDERS	Const / Intermit	Mild/Moderate/Severe	Sharp/Dull
Pain with motion Lt.	1 2	1 2 3	1 2
Rt.	1 2	1 2 3	1 2
Pain at rest Lt.	1 2	1 2 3	1 2
Rt.	1 2	1 2 3	1 2
Muscle spasm Lt.	1 2	1 2 3	
Rt.	1 2	1 2 3	
Muscle weakness Lt.	1 2	1 2 3	
Rt.	1 2	1 2 3	

	Frequency	Intensity	Pain type
E) ARMS	Const / Intermit	Mild/Moderate/Severe	Sharp/Dull
UPPER arm pain Lt.	1 2	1 2 3	1 2
Rt.	1 2	1 2 3	1 2
Pins & needles Lt.	1 2	1 2 3	
(Upper arm) Rt.	1 2	1 2 3	
Numbness Lt.	1 2	1 2 3	
(Upper arm) Rt.	1 2	1 2 3	
Muscle weakness Lt.	1 2	1 2 3	
(Upper arm) Rt.	1 2	1 2 3	
ELBOW pain Lt.	1 2	1 2 3	1 2
Rt.	1 2	1 2 3	1 2
FOREARM pain Lt.	1 2	1 2 3	1 2
Rt.	1 2	1 2 3	1 2
Pins & needles Lt.	1 2	1 2 3	
(Forearm) Rt.	1 2	1 2 3	
Numbness Lt.	1 2	1 2 3	
(Forearm) Rt.	1 2	1 2 3	
Muscle weakness Lt.	1 2	1 2 3	
(Forearm) Rt.	1 2	1 2 3	
F) HANDS	Const / Intermit	Mild/Moderate/Severe	Sharp/Dull
Wrist pain Lt.	1 2	1 2 3	1 2
Rt.	1 2	1 2 3	1 2
Hand pain Lt.	1 2	1 2 3	1 2
Rt.	1 2	1 2 3	1 2
Pins & needles Lt.	1 2	1 2 3	
Rt.	1 2	1 2 3	
Numbness hand Lt.	1 2	1 2 3	
Rt.	1 2	1 2 3	
Thumb pain Lt.	1 2	1 2 3	1 2
Rt.	1 2	1 2 3	1 2
Index finger pain Lt.	1 2	1 2 3	1 2
Rt.	1 2	1 2 3	1 2
Middle finger pain Lt	1 2	1 2 3	1 2
Rt.	1 2	1 2 3	1 2
Ring finger pain Lt.	1 2	1 2 3	1 2
Rt.	1 2	1 2 3	1 2
Little finger pain Lt.	1 2	1 2 3	1 2
Rt.	1 2	1 2 3	1 2
Numbness-finger Lt.	Index____ Middle____ Ring____ Litle____ Thumb____		
Rt.	Index____ Middle____ Ring____ Litle____ Thumb____		
Muscle weakness Lt.	1 2	1 2 3	
Rt.	1 2	1 2 3	
G) MIDBACK	Const / Intermit	Mild/Moderate/Severe	Sharp/Dull
Pain Lt.	1 2	1 2 3	1 2
MIDDLE	1 2	1 2 3	1 2
Rt.	1 2	1 2 3	1 2
Muscle spasm Lt.	1 2	1 2 3	
Rt.	1 2	1 2 3	
H) LOWBACK	Const / Intermit	Mild/Moderate/Severe	Sharp/Dull
Pain Lt.	1 2	1 2 3	1 2
MIDDLE	1 2	1 2 3	1 2
Rt.	1 2	1 2 3	1 2
Stiffness	1 2	1 2 3	
Muscle spasm Lt.	1 2	1 2 3	
Rt.	1 2	1 2 3	
Pain radiates to Lt.	Buttocks____ Hip____ Side of Leg____ Back of Leg____		
Rt.	Buttocks____ Hip____ Side of Leg____ Back of Leg____		

PATIENT COMPLAINTS - continued

Patient Name: _____ Date: _____

PLEASE FILL OUT ONLY THE ITEMS THAT APPLY TO YOUR PAIN

		Frequency		Intensity			Pain type	
I) PELVIS		Const / Intermit		Mild/Moderate/Severe			Sharp/Dull	
Hip joint pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Sacroiliac pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Buttock pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Groin pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Tail bone pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
J) THIGH		Const / Intermit		Mild/Moderate/Severe			Sharp/Dull	
Pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Pain radiates to	Lt.	Knee____ Calf____ Ankle____						
	Rt.	Knee____ Calf____ Ankle____						
Numbness		1	2	1	2	3		
Pins & needles	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Knee pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Swollen knee	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Muscle weakness	Lt	1	2	1	2	3		
	Rt.	1	2	1	2	3		
K) CALVES		Const / Intermit		Mild/Moderate/Severe			Sharp/Dull	
Calf pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Pain radiates to	Lt.	Ankle____ Foot____ Toes____						
	Rt.	Ankle____ Foot____ Toes____						
Numbness	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Pins & needles	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Cramps	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Muscle weakness	Lt	1	2	1	2	3		
	Rt.	1	2	1	2	3		
L) ANKLES		Const / Intermit		Mild/Moderate/Severe			Sharp/Dull	
Pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Swelling	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
M) FEET		Const / Intermit		Mild/Moderate/Severe			Sharp/Dull	
Pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Numbness	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Pins & needles	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Swelling	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Cramps	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Specify toe pain	Lt.	Big____ 2nd____ Mid____ 4th____ Sml____					1	2
	Rt.	Big____ 2nd____ Mid____ 4th____ Sml____					1	2

	Frequency		Intensity			Pain type	
N) CHEST	Const / Intermit		Mild/Moderate/Severe			Sharp/Dull	
Deep chest pain	1	2	1	2	3	1	2
Pain around ribs Lt.	1	2	1	2	3	1	2
Rt.	1	2	1	2	3	1	2
Pain with exertion	1	2	1	2	3	1	2
Shortness of breath	1	2	1	2	3		
Difficulty breathing	1	2	1	2	3		
Irregular heartbeat	1	2	1	2	3		
Rapid heartbeat	1	2	1	2	3		
Night sweats	1	2	1	2	3		
Chronic cough	1	2	1	2	3		
O) DIGESTIVE TRACT	Const / Intermit		Mild/Moderate/Severe			Sharp/Dull	
Stomach pain	1	2	1	2	3	1	2
Indigestion	1	2	1	2	3		
Nausea	1	2	1	2	3		
Gas	1	2	1	2	3		
Clay colored stool	1	2	1	2	3		
Black tarry stool	1	2	1	2	3		
Hemorrhoids	1	2	1	2	3		
Bleeding from rectum	1	2	1	2	3		
Abnormal weight loss			1	2	3		
Diarrhea	1	2	1	2	3		
Constipation	1	2	1	2	3		
P) URINARY TRACT	Const / Intermit		Mild/Moderate/Severe			Sharp/Dull	
Painful urination	1	2	1	2	3	1	2
Frequent urination	1	2	1	2	3		
Unable to urinate	1	2	1	2	3		
Leakage of urine	1	2	1	2	3		
Blood in urine	1	2	1	2	3		
Bedwetting	1	2	1	2	3		
Q) WOMEN ONLY	1	2	1	2	3	1	2
Painful menstruation	1	2	1	2	3	1	2
Excess menstruation	1	2	1	2	3	1	2
Missed/irregular periods	1	2	1	2	3	1	2

SUMMARY:

You have identified general complaints in different parts of your body. Enter the letter (A thru Q) to tell us:

1) Where is your most serious complaint _____
2) Where is your next most serious complaint _____
3) The approximate date of onset _____
4) Was onset: Sudden _____Gradual _____
5) Are the complaints…
   a) Improving _____ b) Getting worse _____
   c) About the same _____ d) Intermittent (comes & goes) _____
6) When are the complaints most noticeable?
   a) Morning _____ b) Afternoon _____
   c) Evening _____ d) Night _____
7) What aggravates the complaints?
   a) Standing _____ b) Walking _____ c) Sitting _____ d) Bending _____
   e) Lying _____ f) Lifting _____ g) Twisting _____ h) Coughing _____
8) What relieves the complaints?
   a) Rest _____ b) Sitting _____ c) Lying _____ d) Bending _____
   e) Stretching _____ f) Exercise _____ g) Lying with knees bent _____