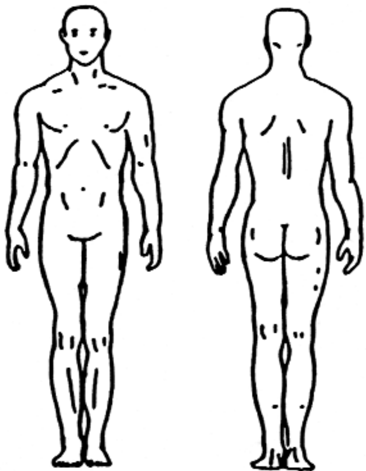
Name:______________________________

Date:______________________________

Draw & Number Your Complaints



List and rate your complaints from 1-10.

1______________________________

No Pain — **PAIN SCALE** — Extreme Pain

1 2 3 4 5 6 7 8 9 10

Full Function — **FUNCTION SCALE** — No Function

1 2 3 4 5 6 7 8 9 10

2______________________________

No Pain — **PAIN SCALE** — Extreme Pain

1 2 3 4 5 6 7 8 9 10

Full Function — **FUNCTION SCALE** — No Function

1 2 3 4 5 6 7 8 9 10

3______________________________

No Pain — **PAIN SCALE** — Extreme Pain

1 2 3 4 5 6 7 8 9 10

Full Function — **FUNCTION SCALE** — No Function

1 2 3 4 5 6 7 8 9 10

4______________________________

No Pain — **PAIN SCALE** — Extreme Pain

1 2 3 4 5 6 7 8 9 10

Full Function — **FUNCTION SCALE** — No Function

1 2 3 4 5 6 7 8 9 10

5______________________________

No Pain — **PAIN SCALE** — Extreme Pain

1 2 3 4 5 6 7 8 9 10

Full Function — **FUNCTION SCALE** — No Function

1 2 3 4 5 6 7 8 9 10

6______________________________

No Pain — **PAIN SCALE** — Extreme Pain

1 2 3 4 5 6 7 8 9 10

Full Function — **FUNCTION SCALE** — No Function

1 2 3 4 5 6 7 8 9 10

Please follow directions on the back to complete this form.

Problem	1	2	3	4	5	6
Onset						
Frequency						
Severity						
Quality						
Radiation						
Aggravated by						
Relieved by						

Any other problems?____

____

Please describe each area separately and list your most serious complaints in order of importance.

1) ONSET: When do the symptoms first appear?

____

____

2) FREQUENCY

Rare = 10% of the time
Occasional = 25% of the time
Intermittent = 50% of the time
Frequent = 75% of the time
Constant = 100% of the time

3) SEVERITY

Mild = only a nuisance
Slight = causes a slight handicap
Moderate = causes a marked handicap
Severe = unable to work

4) QUALITY

Dull ache, Sharp, Stabbing, Burning, Throbbing, Cramping, Stinging, Pins and Needles, Numbness

5) RADIATION L = Left R = Right

Down the arm (L) or (R) or both
Into fingers
Across shoulder (L) or (R) or both
Across shoulder (L) or (R) or both
Down back
To shoulder blade (L) or (R) or both
To buttocks, (L) or (R) or both
To thigh, back, front, (L) or (R) or both
To lower leg, back, front, (L) or (R) or both
To feet, top, bottom, front, (L) or (R) or both
To toes, top bottom, front, (L) or (R) or both

6) AGGRAVATED BY

Describe which activities or positions make condition worse such as prolonged sitting, walking driving, working at computer, sleeping, etc.

7) RELIEVED BY

Describe what brings some measure of relief such as rest, ice, heat, sleep, aspirin, other drugs, exercise, stretching, chiropractic care, physical therapy.