Complaint History

Patient Name _____ **Date** _____

Current Health Complaint: ***(Give a brief, detailed description of the problem you are currently experiencing)***

When did this problem start (date)? | How did it start?

How often do you feel it? ☐ 0-25% of the time (intermittent), ☐ 26-50% of the time (occastional), ☐ 51-75% of the time (frequently), ☐ 76-100% of the time (constantly)

What does it feel like? *(Please check all that apply):*

☐ Achy ☐ Burning ☐ Congestion ☐ Cramping ☐ Crawling ☐ Dull ☐ Electric-like ☐ Fatigue ☐ Itchy ☐ Nagging ☐ Numb
☐ Pounding ☐ Pressure ☐ Pulling ☐ Sharp ☐ Shooting ☐ Sore ☐ Spasm ☐ Stabbing ☐ Stiff ☐ Stressed ☐ Tight ☐ Tingling
☐ Throbbing ☐ Weakness ☐ Sharp with motion ☐ Shooting with motion ☐ Stabbing with motion ☐ Electric-like with motion

Does it radiate to anywhere? *(please describe)* :

On a Scale of 0 to 10 - where 0 is no pain and 10 is the worst pain ever - please circle the numbers that apply:
Level you feel the most: 0 1 2 3 4 5 6 7 8 9 10, Level when it feels the best: 0 1 2 3 4 5 6 7 8 9 10, Level when it feels the worst: 0 1 2 3 4 5 6 7 8 9 10

Does anything make it feel worse? *(Please check all that apply):*

☐ Bending forward ☐ Bending backward ☐ Bending or leaning right ☐ Bending or leaning left ☐ Twisting right ☐ Twisting left
☐ Climbing stairs ☐ Coughing ☐ Driving ☐ Exercising ☐ Kneeling ☐ Laying on your back ☐ Laying on your (R) side ☐ Laying on your (L) side
☐ Carrying ☐ Lifting ☐ Pushing ☐ Pulling ☐ Running ☐ Sleeping ☐ Sneezing ☐ Sitting ☐ Standing ☐ Straining ☐ Stretching
☐ Walking ☐ Work duties ☐ Feels worse in the A.M. ☐ Feels worse in the P.M. ☐ Nothing specific makes it feel worse
☐ Other *(please describe)* :

Does anything make it feel better? *(Please check all that apply):*

☐ Bending forward ☐ Bending backward ☐ Bending or leaning right ☐ Bending or leaning left ☐ Resting ☐ Sleeping
☐ Laying on your back ☐ Laying on your (R) side ☐ Laying on your (L) side ☐ Massage ☐ Moving around ☐ Sitting ☐ Standing ☐ Walking
☐ Stretching ☐ Icing the symptomatic area ☐ Heat on the symptomatic area ☐ OTC Medication ☐ Prescription medication
☐ Feels better in the A.M. ☐ Feels better in the P.M. ☐ Nothing specific makes it feel better
☐ Other *(please describe)* :

Have you received **previous treatment** for this condition? From who? ☐ Yes, ☐ No
☐ Medical Doctor ☐ Chiropractor ☐ Physical Therapist ☐ Other:

Did the treatment help?
☐ It improved ☐ Got Worse ☐ There was no change

Activites of Daily Living *(Please mark a number, as described below, for all the problems you are experiencing)*

0 = Not a Problem, 1 = Mild difficulty (can do it but with pain), 2 = Moderate difficulty (have pain and it really hurts), 3 = Significant difficulty (unable to perform without agonizing pain)

Hygiene: ___ Bathing ___ Showering ___ Washing your hair ___ Drying your hair ___ Combing your hair ___ Washing your face ___ Brushing your teeth
___ Using the toilet ___ Putting on make-up ___ Shaving your legs ___ Shaving your face

Self Care: ___ Cleaning dishes ___ Eating ___ Preparing meals ___ Putting on a shirt ___ Hooking your Bra ___ Putting on pants ___ Putting on shoes
___ Tying your shoes ___ Cleaning your home ___ Doing laundry ___ Making your bed ___ Getting normal, restful sleep at night
___ Participating in desired sexual activity

Work: ___ Concentrating ___ Using a keyboard ___ Writing ___ Performing work Duties

Activities: ___ Climbing ___ Driving ___ Golfing ___ Jogging ___ Personal hobbies ___ Playing sports ___ Running ___ Walking ___ Weightlifting
___ Exercising ___ Exercising upper body ___ Exercising lower body ___ Exercising arms ___ Exercising legs

Movement: ___ Carrying your purse ___ Carrying small objects ___ Carrying large objects ___ Climbing Stairs ___ Climbing inclines ___ Grasping objects
___ Lifting ___ Pushing ___ Pulling ___ Reaching ___ Reclining ___ Kneeling ___ Sitting ___ Standing
___ Bending forward ___ Bending Back ___ Bending/Leaning right ___ Bending/Leaning left ___ Twisting right ___ Twisting left
___ kneeling for long periods ___ Sitting for long periods ___ Standing for long periods ___ Walking for long periods

Other *(please describe)* **:**