

# Subjective Complaints

Chief Complaint(s): \_\_\_\_\_

Explain how and when it happened: \_\_\_\_\_

Complaints/ symptoms:  Come and go  Came on gradually  Came on suddenly  
 Have been getting worse  Have stayed the same  Have been getting better

Did the symptoms develop from:  Work related injury  Auto accident  Neither

**Describe Complaints** (name body parts): \_\_\_\_\_

**Character of Complaint(s):**  Pain  Spasm  Tender  Sore  Ache  Stiff  Weak  Numb

**Pain Level:** On a scale of 0-10, with 0 being you're  
 Pain free and can function well, and 10 being you're  
 In excruciating pain and cannot function at all, please  
 Rate the severity of your pain.

|      |   |      |   |          |   |         |   |            |   |      |
|------|---|------|---|----------|---|---------|---|------------|---|------|
| 0    | 1 | 2    | 3 | 4        | 5 | 6       | 7 | 8          | 9 | 10   |
| no   |   | low  |   | moderate |   | intense |   | unbearable |   |      |
| pain |   | pain |   | pain     |   | pain    |   | pain       |   | pain |

What makes your condition worse?  Nothing  Lifting  Trying to stand  Standing  
 Walking  Sitting  Movement  Exercise  Inactivity  Work/ home activities

What makes your condition better?  Nothing  Standing  Walking  Sitting  
 Movement  Exercise  Inactivity  Lying down  Sleep  Stretch  
 Hot shower/ bath  Other

Have you ever had these complaints before?  Yes  No

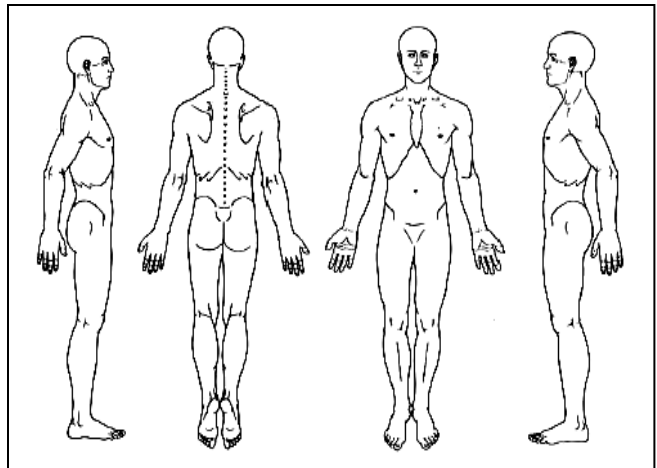
If yes, when? \_\_\_\_\_

Give name(s) of doctor(s) previously seen for this condition: \_\_\_\_\_

## ABILITY TO PERFORM THE FOLLOWING ACTIVITIES:

**Codes: U= Unable P= Painful D= Difficult L= Limited N= Normal**

- |  |  |
|--|--|
| <input type="checkbox"/> Coughing/ Sneezing            | <input type="checkbox"/> Climbing        |
| <input type="checkbox"/> Getting in or out of a car    | <input type="checkbox"/> Kneeling        |
| <input type="checkbox"/> Bending forward               | <input type="checkbox"/> Balancing       |
| <input type="checkbox"/> Putting on clothes            | <input type="checkbox"/> Sitting         |
| <input type="checkbox"/> Putting on shoes              | <input type="checkbox"/> Looking back    |
| <input type="checkbox"/> Turning over in bed           | <input type="checkbox"/> Sleeping        |
| <input type="checkbox"/> Getting out of bed            | <input type="checkbox"/> Stooping        |
| <input type="checkbox"/> Standing longer than 10 min   | <input type="checkbox"/> Gripping        |
| <input type="checkbox"/> Standing longer than 1 hour   | <input type="checkbox"/> Pushing         |
| <input type="checkbox"/> Walking short distances       | <input type="checkbox"/> Pulling         |
| <input type="checkbox"/> Lying on your stomach         | <input type="checkbox"/> Reaching        |
| <input type="checkbox"/> Lying on side with knees bent | <input type="checkbox"/> Sexual activity |



## CHECK NERVOUS SYSTEM COMPLAINTS

- |   |  |
|---|--|
| <input type="checkbox"/> Blurring vision          | <input type="checkbox"/> Headaches                   |
| <input type="checkbox"/> Buzzing/ ringing in ears | <input type="checkbox"/> How often do have headaches |
| <input type="checkbox"/> Confusion                | <input type="checkbox"/> Loss of sleep               |
| <input type="checkbox"/> Convulsions              | <input type="checkbox"/> Low resistance              |
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Muscle jerking              |
| <input type="checkbox"/> Fainting                 | <input type="checkbox"/> Numbness                    |
| <input type="checkbox"/> Paralysis                |  |

(WOMEN ONLY) Are you pregnant?  No  Yes  
 Date of onset of last menstrual cycle: \_\_\_\_\_

Symptoms are better in:  AM  Midday  PM  
 Symptoms are worse in:  AM  Midday  PM  
 Symptoms do **not** change with time of day

Dates of last x- rays taken if  
 applicable: \_\_\_\_\_  
 What were they taken for? \_\_\_\_\_

Significant Family History of Chronic Disease:

Name: \_\_\_\_\_

Date: \_\_\_\_\_