Updated Subjective Complaints

Name:_____ Date:_____

Present Complaints:
Headache/Neck/Arms/Hands: ___ Pain ___ Spasm ___ Tender ___ Sore ___ Ache
___ Stiff ___ Shooting ___ Weakness ___ Numbness ___Other:_____
How has your condition/symptoms changed since your last exam? ___ Less ___ Same ___ More
___ Increased Motion ___ Same Motion ___ Decreased Motion

Mid Back/Shoulder(s): ___ Pain ___ Spasm ___ Tender ___ Sore ___ Ache
___ Stiff ___Shooting ___ Weakness ___ Numbness ___ Other: _____
How has your condition/symptoms changed since your last exam? ___ Less ___ Same ___ More
___ Increased Motion ___ Same Motion ___ Decreased Motion

Low Back/Hips/Legs/Feet: ___ Pain ___ Spasm ___ Tender ___ Sore ___ Ache
___ Stiff ___ Shooting ___ Weakness ___ Numbness ___ Other:_____
How has your condition/symptoms changed since your last exam? ___ Less ___ Same ___ More
___ Increased Motion ___ Same Motion ___ Decreased Motion

Nervous System Complaints: ___ Blurred Vision ___ Ringing in Ears ___ Confusion ___Convulsions
___ Depression/Crying Spells ___ Dizziness ___ Fainting ___ Paralysis ___Numbness
___ Headaches (how often)_____ ___ Loss of Sleep ___ Fatigue ___ Muscle Jerking

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 all the time, where would you rate the intensity of your pain?

(Low Pain) (Moderate Pain) (Intense Pain)

0 1 2 3 4 5 6 7 8 9 10

Describe any accident/injury/diseases since your last visit:_____
What makes your condition worse? ___ Nothing ___ Lifting ___ Trying to Stand ___ Standing ___Walking
___ Sitting ___ Movement ___ Exercise ___ Inactivity ___ Work Activities ___ Home Activities
___ Other:_____

What makes your condtion better? ___ Nothing ___ Standing ___ Lying Down ___ Walking ___ Sitting
___ Movement ___ Exercise ___ Inactivity ___ Sleep ___ Hot Shower/Bath ___Stretching
___ Other:_____

Please rate your ability to perform the
Following activities: **U-Unable; P-Pain/Difficult**
L-Limited; N-normal

___ Cough/Sneeze
___ Getting in/out of car
___ Bending Forward
___ Putting on Clothes
___ Putting on Shoes
___ Turning over in Bed
___ Getting Out of Bed
___ Standing More Than 10 Min
___ Standing More Than 60 Min
___ Walking Short Distances
___ Lying Flat on Stomach
___ Lying on Side
___ Climbing
___ Kneeling
___ Balancing
___ Sitting
___ looking Back
___ Sleeping
___ Stooping
___ Gripping
___ Pushing
___ Pulling
___ Reaching
___ Sexual Activity

Symptoms are better in: ___ A.M. ___ P.M.
Symptoms are worse in: ___ A.M. ___ P.M.
Please rate your satisfaction with treatment received:
___ Very Pleased ___ Pleased ___ Not Pleased