PAIN/COMPLAINT QUESTIONNAIRE

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NAME: _____ **DATE:** _____

Describe your symptoms: _____
_____

When did your symptoms start? _____

How did it start? _____

What makes it better? _____

What makes it worse? _____

What can't you do because of this condition? _____

What do you want to be able to do?_____

Circle your answer:

How often do you experience your symptoms?

Constant (all day) Frequently (3/4 of the day) Occasional (1/2 of the day) Intermittent (1/4 of the day)

How does it feel? Sharp Dull Numb Shooting Burning Tingling

What is the average intensity of your symptoms from 0 - 10?

(*No Pain)* 0 1 2 3 4 5 6 7 8 9 10 (*Severe Pain)*

Who have you seen for your symptom(s)?

No one Other Chiropractor MD/DO PT Massage Therapist

What treatment did you get and when? _____

What tests were performed? (when and where?)

Xrays Date: _____ Where? _____
MRI Date: _____ Where? _____
CAT SCAN Date: _____ Where? _____

Have you had this before? Yes _____ No _____ If yes, who did you see?

This office Other Chiropractor MD/DO PT Other _____