UPDATED SUBJECTIVE COMPLAINTS

Full Name:_____ **Date**:_____

CURRENT COMPLAINTS:

Head & Neck:_____

Mid-Back, Shoulders, Arms & Hands:_____

Low-Back, Hips, Legs & Feet:_____

How have your symptoms changed since you started care: Increasing Decreasing Not Changing

How bad is your pain or discomfort? (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

Is the pain: Constant (76-100%) Frequent (51-75%) Intermittent (26-50%) Occasional (25% or less)

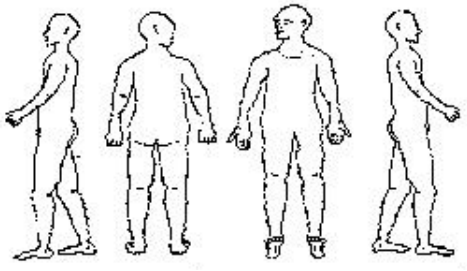
What makes your pain better?_____

What makes your pain worse?_____

Describe any accidents/injuries/diseases since your last visit and when they occurred:

_____

Check the area that you are experiencing pain:



Symptoms are better in: AM MIDDAY PM
Symptoms are worse in: AM MIDDAY PM
Symptoms do not change with the time of day ☐

How do you classify your improvements so far:
Excellent Good Okay Poor No improvement

Is there anything you can think of that might be hindering your progress?:_____

Circle your nervous system complaints:

Loss of energy	Depression	Loss of memory
Blurred vision	Dizziness	Ringing/Buzzing in ears
Crying spells	Difficulty sleeping	Other:_____

Indicate ability to perform the following activities: U = Unable P = Painful D = Difficult L = Limited N = Normal

__coughing or sneezing	__walking long distances	__lying flat on stomach
__climbing	__sleeping	__pulling
__getting in and out of car	__standing for more than 1 hr	__lying on side with knees bent
__kneeling	__reaching	__bending forward to brush teeth
__sitting for more than 1 hr	__bending forward	__balancing
__gripping	__sexual activity	__turning over in bed
__lying on back	__dressing self	__pushing
__other:_____		

Your cooperation in providing us with the accurate information on this form will enable us to provide quality chiropractic health care.

Date:_____ **Signature**:_____ Updated 9/20/16