OUTTEN CHIROPRACTIC & Cary Spinal Decompression Center 401 High House Rd.
Suite 110 Cary, NC 27513

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: Increasing Decreasing Not Changing
How bad is your pain or ache? 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (unbearable)
Is the pain: Constant (76-100%) Frequent (51-75%) Intermittent (26-50%)
Occasional (25% or less)

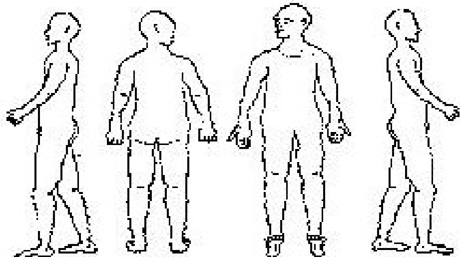
What makes your pain better?____

What makes your pain worse?____

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

____

Check where 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	__stooping	__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	__other:__________________
__dressing self	__pushing	

Have you tried to refer anyone for chiropractic care? Yes No
Would you be willing to be our patient of the month? Yes No

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

Date:____________________________ **Signature**:____ Updated 6/3/14