

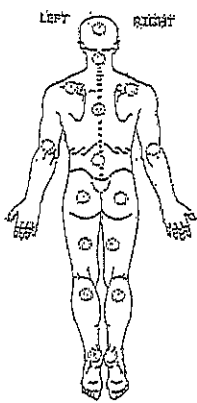
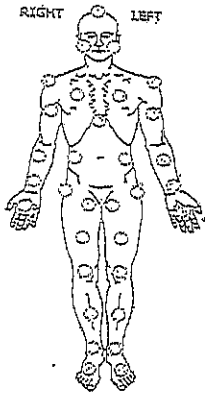
Name: _____ Date: _____ Pt. #: _____



COMPLAINT
(Initial Exam, Daily Note, Follow Up/Final Exam)

Complaint # ___ -
Please place an X on one part of the body where you are experiencing pain or discomfort and list your complaints in the order of severity. (If you do not see your complaint on the picture, please list the complaint on the Other line.

Please grade pain 0-10 (10 is the highest) ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩



Other: _____

This complaint came on:

It is getting:

The intensity of this complaint is:

The frequency of this complaint is: Intermittent

The pain is:

The pain is located on:

Actions effecting this complaint:

- Morning
- Afternoon
- Cold
- Heat
- Medication
- Resting
- Straining
- Standing
- Sitting
- Lying down
- Bending forward
- Bending back
- Bending left
- Twisting left
- Twisting right
- Lifting
- Coughing
- Sneezing

- Gradually
- Improving
- Minimal Slight
- Occasional
- Dull
- Shooting
- Burning
- Left side

- Immediately
- Staying the same
- Moderate
- Frequent
- Sharp
- Spasm
- Spasm
- Right side

- Getting Worse
- Severe
- Constant
- Aching
- Throbbing
- Tingling
- Both sides

- Brings On
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- Aggravates
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