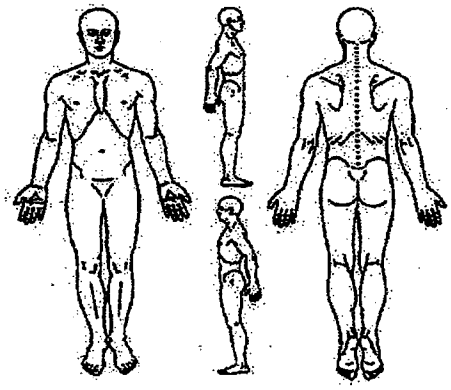
Name_____DOB:___/___/___ Date:_____
Indicate severity of symptoms : 0=no pain to 10=most severe pain

Second Complaint



Describe and mark on person to the left your complaint:_____
_____
_____
_____Is it Overuse: Yes No

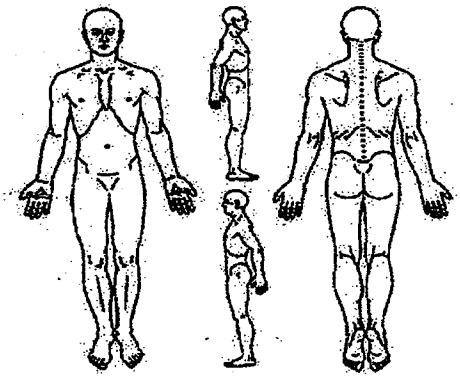
How Long has it been going on:_____
Is there any shooting pain Yes No
Were?_____

Circle all that apply:

At it's **WORST** 1 2 3 4 5 6 7 8 9 10 Sharp
At it's **BEST** 1 2 3 4 5 6 7 8 9 10 Dull
Constant (76-100% of day) Achy
Frequent (51-75%) Numb
Occasional (26-50%) Shooting
Intermittent (0-25%) Tingling

Relieved by:_____
_____
Aggravated by: _____
_____
Xray- yes no when? _____
MRI- yes no when? _____
ANYTHING ELSE?_____
_____
_____

Third Complaint



Describe and mark on person to the left your complaint:_____
_____
_____
_____Is it Overuse: Yes No

How Long has it been going on:_____
Is there any shooting pain Yes No
Were?_____

Circle all that apply:

At it's **WORST** 1 2 3 4 5 6 7 8 9 10 Sharp
At it's **BEST** 1 2 3 4 5 6 7 8 9 10 Dull
Constant (76-100% of day) Achy
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Relieved by:_____
_____
Aggravated by: _____
_____
Xray- yes no when? _____
MRI- yes no when? _____
ANYTHING ELSE?_____
_____