WRITE LEGIBLY

WC/PI
SUBJECTIVE COMPLAINTS

WRITE LEGIBLY

PAYMENT is due at the time of service, unless other arrangements have been made.
Patients involved in **LITIGATION** (law suits) are responsible for their services here at the clinic.

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT I HAVE READ THE ABOVE POLICIES AND AGREE TO ABIDE BY SAME.

PATIENT SIGNATURE _____ WITNESS _____

GUARDIAN SIGNATURE _____ Phone: (Home)_____ (Work)_____

Patient Name _____ ☐ Male ☐ Female Birthdate_____

Street/P.O. Box _____ Age_____ Height: _____" Weight _____ lbs.

City/State/Zip _____ Soc. Sec. #_____ Driver's License # _____

Who referred you to our clinic? _____ Emergency Name/Phone:_____

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10. DESCRIBE COMPLAINTS: *PLEASE BE SPECIFIC*

a) Involving Neck & Head: _____

b) Involving Mid-back / Shoulders / Arms & Hands: _____

c) Involving Low Back / Hips / Legs & Feet: _____

20. PAIN LEVEL: On a scale of 0–10, with 0 being you're pain free and can function quite well, and 10 being you're in pain all the time and cannot function at all, where would you rate yourself?

0 1 2 3 4 5 6 7 8 9 10

NO PAIN — LOW PAIN — MODERATE PAIN — INTENSE PAIN — EXCRUCIATING PAIN

30. WHAT ACTIVITIES MAKES CONDITION WORSE? _____

40. WHAT ACTIVITIES MAKES CONDITION BETTER? _____

50–80. INDICATE ABILITY TO PERFORM THE FOLLOWING ACTIVITIES:

USE CODES: **U=Unable/50 P=Painful/60 D=Difficult/70 L=Limited/70 N=Normal/80**

____ Coughing or sneezing
____ Getting in or out of a car
____ Bending forward to brush teeth
____ Turning over in bed
____ Walking short distances
____ Standing for more than 1 hour
____ Sitting at a table
____ Lying on back
____ Lying flat on stomach
____ Lying on side with knees bent
____ Bending over forward
____ Climbing
____ Kneeling
____ Balancing
____ Dressing self
____ Sleeping
____ Stooping
____ Gripping
____ Pushing
____ Pulling
____ Reaching
____ Sexual activity

90. CHECK YOUR NERVOUS SYSTEM COMPLAINTS

☐ Blurring vision
☐ Buzzing or ringing in ears
☐ Confusion
☐ Convulsions
☐ Depression or crying spells
☐ Dizziness
☐ Fainting
☐ Paralysis
☐ Headaches
☐ How often do you have headaches?_____
☐ Loss of sleep
☐ Low resistance
☐ Muscle jerking
☐ Numbness

CHECK PROPER SPACE:

100. Symptoms are **BETTER** in: ☐ AM ☐ Midday ☐ PM

110. Symptoms are **WORSE** in: ☐ AM ☐ Midday ☐ PM

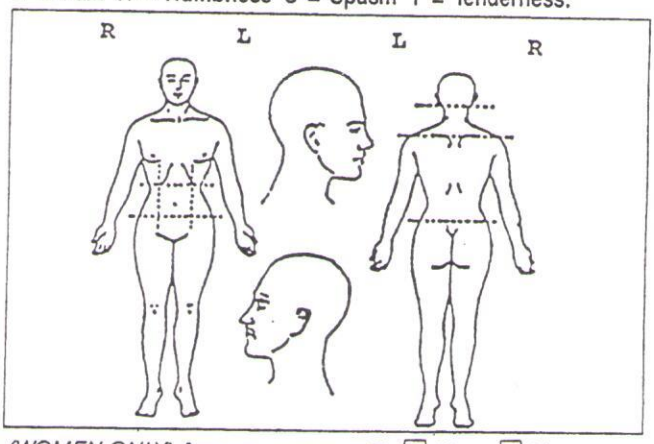
120. ☐ Symptoms do not change with time of day

130–140. FAMILY HISTORY: *(for example: Cancer / Diabetes Heart problems / Back or neck problems)*

Father: Brother/Brothers:
Mother: Sister/Sisters:

150. SHADE AND CODE AREA(S) TO INDICATE LOCATION OF PAIN OR DISCOMFORT:

USE CODES:
P = Pain N = Numbness S = Spasm T = Tenderness:



160. *(WOMEN ONLY)* **Are you pregnant?** ☐ Yes ☐ No

Date of onset of last menstrual cycle_____

170. Give date of last X-rays: _____

Name _____

Date _____ File#_____

