WRITE LEGIBLY

SUBJECTIVE COMPLAINTS

WRITE LEGIBLY

10 Explain **WHEN** and **HOW** it happened:____________________

20 COMPLAINTS/SYMPTOMS: ___Come and go ___Came on gradually ___Came on suddenly

30 Symptoms have persisted for: ___Hours ___1 Day ___Days ___Weeks ___Months ___Years

40 Symptoms developed from: ___A work-related injury ___An auto accident ___Neither a work or auto accident

50 PRESENT COMPLAINTS--**PLEASE BE SPECIFIC:**____________________

____

60 **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 excruciating pain all the time, where would you rate the intensity of your pain?

0	1	2	3	4	5	6	7	8	9	10
NO PAIN		LOW PAIN			MODERATE PAIN			INTENSE PAIN		EXCRUCIATING PAIN

70 What makes your condition worse?___Nothing ___Lifting ___Trying to stand ___Standing ___Walking ___Sitting ___Movement ___Exercise ___Inactivity ___Work activities ___Home activities ___________Other

80 What makes your condition better?___Nothing ___Standing ___Walking ___Sitting ___Movement ___Exercise ___Inactivity ___Lying down ___Sleep ___Hot shower/bath ___Stretching ___________Other

90 Have you ever had this condition/problem before? ___No

100 If yes, when?____________________

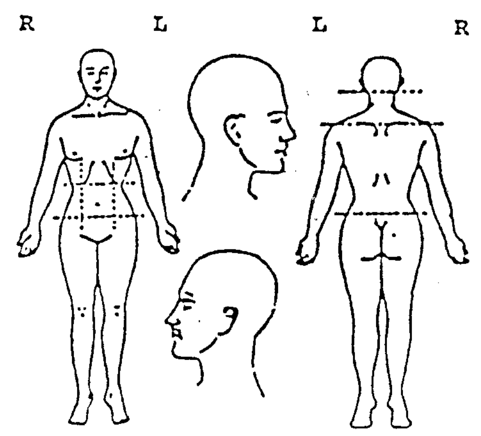
110 Give name(s) of doctor(s) previously seen for this present condition____________________

120 What medications are you presently taking?____________________

130-160 ABILITY TO PERFORM THE FOLLOWING ACTIVITIES:
CODES: **U=Unable/130 P=Painful/140 D=Difficult/150 L=Limited/150 N=Normal/160**

___Coughing or sneezing
___Getting in or out of a car
___Bending over forward
___Putting on clothes
___Putting on shoes
___Turning over in bed
___Getting out of bed
___Standing for more than 10 minutes
___Standing for more than 60 minutes
___Walking short distances
___Lying flat on stomach
___Lying on side with knees bent
___Climbing
___Kneeling
___Balancing
___Sitting
___Looking back
___Sleeping
___Stooping
___Gripping
___Pushing
___Pulling
___Reaching
___Sexual Activity

230 SHADE AND CODE AREA(S) OF COMPLAINT:
USE CODES: **P=Pain N=Numb S=Spasm**



170 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

240 *(WOMEN ONLY) Are you pregnant?*
Date of onset of last menstrual cycle__________

250 Give date of last X-rays:__________

What body parts were they taken of?__________

180 Symptoms are **BETTER** in: ___AM ___Midday ___PM

190 Symptoms are **WORSE** in: ___AM ___Midday ___PM

200 Symptoms do not change with time of day ____

210-220 FAMILY HISTORY: *(heart/lung/back/neck problems)*
Father: Brother(s):
Mother: Sister(s):

Name____________________ Date__________

File #__________ Occupation__________

FORM 20 REV 1/95

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