

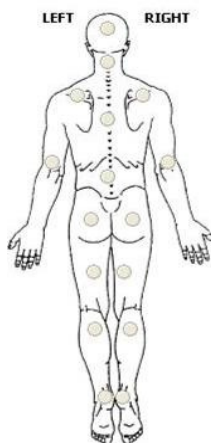
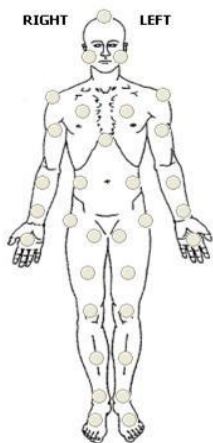
## COMPLAINT

(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) 0 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

Brings On

Brings On

Brings On

Brings On

Brings On

Brings On

Brings On

Brings On

Brings On

Brings On

Brings On

Brings On

Brings On

Brings On

Brings On

Brings On

Brings On

Brings On

Immediately

Staying the same

Moderate

Frequent

Sharp

Spasm

Spasm

Right side

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Getting Worse

Severe

Constant

Aching

Throbbing

Tingling

Both sides

Relieves

Relieves

Relieves

Relieves

Relieves

Relieves

Relieves

Relieves

Relieves

Relieves

Relieves

Relieves

Relieves

Relieves

Relieves

Relieves

Relieves

Relieves