

Primary Complaint Form

Describe primary complaint:

Name: _____

Please outline on the diagram the area of your discomfort
P = Pain N = Numbness S = Stiffness W = Weakness

Date Symptoms last occurred: _____

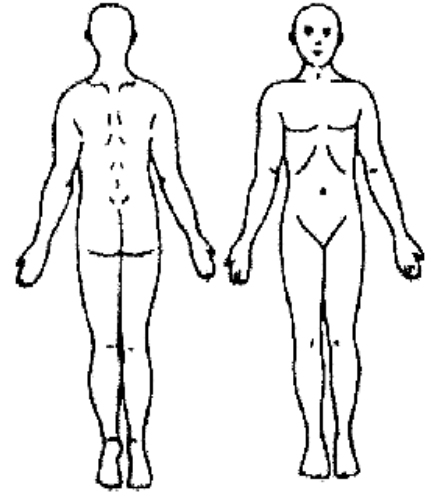
Circle the areas of primary complaint on the Diagram and check the associated symptoms and quality:

Associated Symptoms

- Muscle Spasms
- Tingling
- Headache
- Dizziness
- Fatigue
- Radiation

Quality

- Burning
- Dull Aching
- Localized
- Sharp
- Tightness
- Throbbing



On a scale of 0 out of 10 (0 being no pain and 10 being the most pain possibly imaginable) rate your pain:

_____ At Rest
_____ With Activity

On a scale of 1 out of 3 (1 = minor 2 = can perform with difficulty 3 = can't perform) rate how this injury affects your daily life

- ___ Bending
- ___ Carrying Groceries
- ___ Sitting to Standing
- ___ Climbing Stairs
- ___ Lifting
- ___ Household Chores
- ___ Sleep
- ___ Prolonged Sitting
- ___ Prolonged Standing
- ___ Walking
- ___ Yard Work
- ___ Recreational Activities (list) _____, _____, _____