

CHIEF COMPLAINT

Name: _____

Date: _____

Reason for consulting this office: _____

Show the area(s) of pain or unusual feeling

Mark the areas on this body where you feel the Described sensations. Use the appropriate Symbols. Mark areas of radiation. Include all Affected areas.

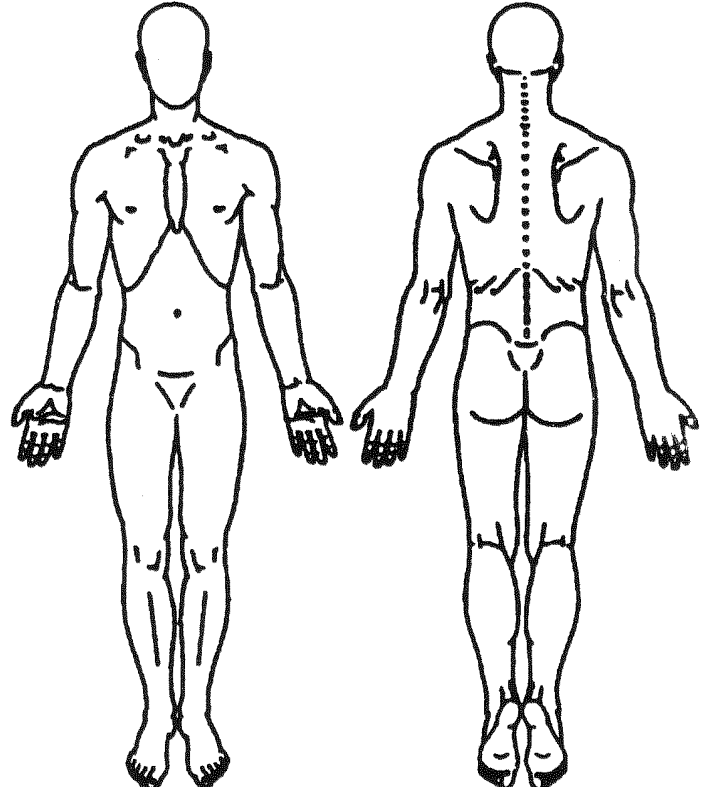
Numbness •••••
 •••••
 •••••

Pins and Needles 00000
 00000
 00000

Burning x x x x x
 x x x x x
 x x x x x

Aching * * * * *
 * * * * *
 * * * * *

Stabbing / / / / /
 / / / / /
 / / / / /



When did this problem begin? _____

What makes this condition worse? _____

What makes it better? _____

Does the pain radiate? YES NO Where? (down the arm, down the leg, etc)

When does it bother you the most? (Morning, Evening, Driving to work. Etc.) _____

What other methods have you tried to relieve the pain? _____

