CHIEF COMPLAINT

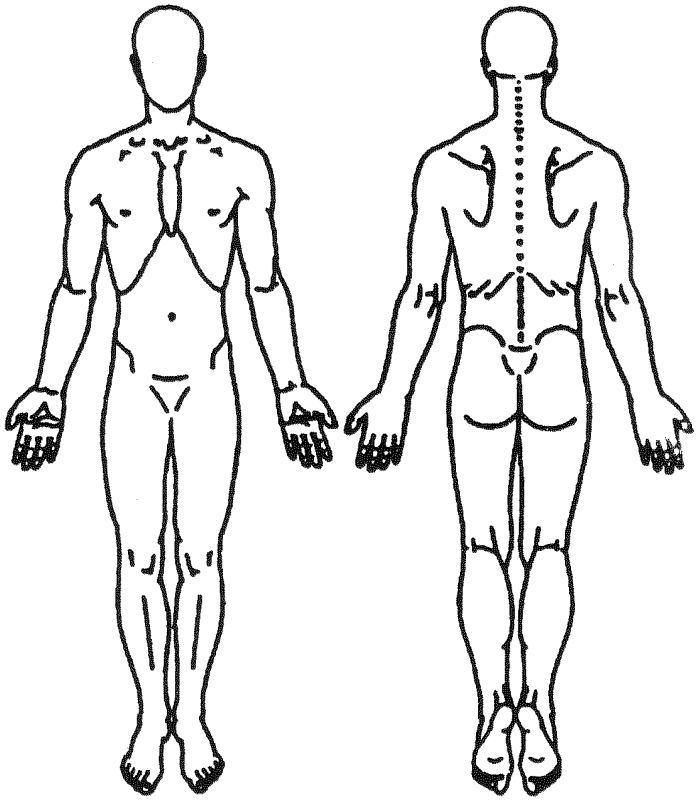
Name: _____ Date:_____

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	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
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 method have you tried to relieve the pain? _____

_____

_____

_____