WRITE LEGIBLY

SUBJECTIVE COMPLAINTS

WRITE LEGIBLY

Explain **WHEN** and **HOW** it happened:_____

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

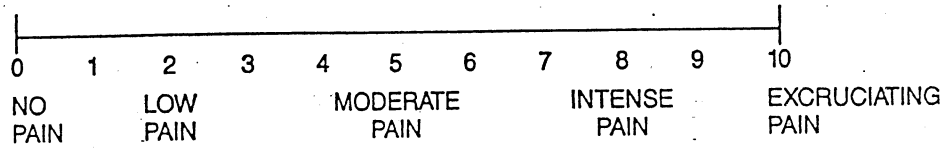
Symptoms have persisted for: ___Hours ___1 Day ___Days ___Weeks ___Months ___Years

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

PRESENT COMPLAINTS--**PLEASE BE SPECIFIC:**_____

_____

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?



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

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

Have you ever had this condition/problem before? ___No

If yes, when?_____

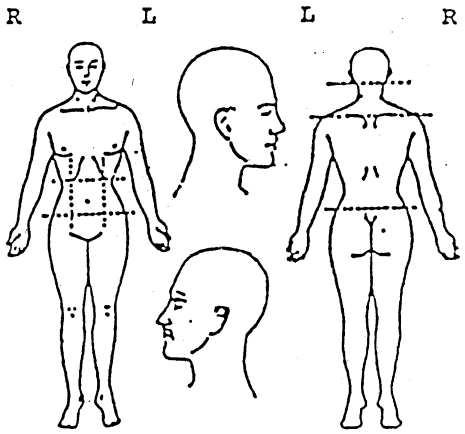
Give name(s) of doctor(s) previously seen for this present condition_____

What medications are you presently taking?_____

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 forward to brush teeth
___Turning over in bed
___Walking short distances
___Standing for more than 1 hour
___Sitting at a table
___Lying on back
___Lying flat on stomach
___Lying on side with knees bent
___Bending over forward
___Climbing
___Kneeling
___Balancing
___Dressing Self
___Sleeping
___Stooping
___Gripping
___Pushing
___Pulling
___Reaching
___Sexual Activity

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



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

(WOMEN ONLY) Are you pregnant?
Date of onset of last menstrual cycle_____

Give date of last X-rays:_____

What body parts were they taken of?_____

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

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

Symptoms do not change with time of day ___

FAMILY HISTORY: *(heart/lung/back/neck problems)*

Father: Brother(s):
Mother: Sister(s):

Name_____ Date_____

File #_____ Occupation_____