

NAME: _____

DOB: _____

MORE THAN ONE COMPLAINT FORM

PROBLEM #2

Area: R L _____

1. How long ago did this start?
_____ day _____ weeks _____ months

2. How did it start?

Same as problem #1?
 Other _____

3. Severity of the pain out of 10 (circle).

0 1 2 3 4 5 6 7 8 9 10

4. What is the type of pain?

Sharp Dull Stabbing
 Throbbing
 Aching Burning

5. Choose One: The pain is:

constant. comes and goes.

6. Does this pain wake you from sleep?

Yes No

7. In this area, do you have:

swelling? bruise?
 underlying numbness?
 tingling? weakness?
 loss of bowel or bladder?

8. What makes your symptoms

worse:

standing? walking?
 lifting? exercise?
 twisting? lying?
 bending? squatting?
 kneeling? stairs?
 sitting? coughing?
 sneezing?

9. Have you had any of these:

injection? Yes No
brace? Yes No
therapy? Yes No

10. Have you had surgery for this problem?

Yes No

Surgeon _____ Year _____

Procedure _____

PROBLEM #3

Area: R L _____

1. How long ago did this start?
_____ day _____ weeks _____ months

2. How did it start?

Same as problem #1?
 Other _____

3. Severity of the pain out of 10 (circle).

0 1 2 3 4 5 6 7 8 9 10

4. What is the type of pain?

Sharp Dull Stabbing
 Throbbing
 Aching Burning

5. Choose One: The pain is:

constant. comes and goes.

6. Does this pain wake you from sleep?

Yes No

7. In this area, do you have:

swelling? bruise?
 underlying numbness?
 tingling? weakness?
 loss of bowel or bladder?

8. What makes your symptoms

worse:

standing? walking?
 lifting? exercise?
 twisting? lying?
 bending? squatting?
 kneeling? stairs?
 sitting? coughing?
 sneezing?

9. Have you had any of these:

injection? Yes No
brace? Yes No
therapy? Yes No

10. Have you had surgery for this problem?

Yes No

Surgeon _____ Year _____

Procedure _____

PROBLEM #4

Area: R L _____

1. How long ago did this start?
_____ day _____ weeks _____ months

2. How did it start?

Same as problem #1?
 Other _____

3. Severity of the pain out of 10 (circle).

0 1 2 3 4 5 6 7 8 9 10

4. What is the type of pain?

Sharp Dull Stabbing
 Throbbing
 Aching Burning

5. Choose One: The pain is:

constant. comes and goes.

6. Does this pain wake you from sleep?

Yes No

7. In this area, do you have:

swelling? bruise?
 underlying numbness?
 tingling? weakness?
 loss of bowel or bladder?

8. What makes your symptoms

worse:

standing? walking?
 lifting? exercise?
 twisting? lying?
 bending? squatting?
 kneeling? stairs?
 sitting? coughing?
 sneezing?

9. Have you had any of these:

injection? Yes No
brace? Yes No
therapy? Yes No

10. Have you had surgery for this problem?

Yes No

Surgeon _____ Year _____

Procedure _____