Complaint Form Side 1: Please complete both sides of this form

Gardiner Family Chiropractic 90 Main Avenue, Gardiner, Me 04345 (207) 582-2222

Full Name:_____ Date:_____

Office Use Only: __New Patient __Reactivation __Progress Exam __Active Patient New Injury __Active Patient New Area of Complaint

Chief Complaint:_____ Date of onset:_____ Related to accident/injury? Y / N

If yes, please describe:_____

Intensity of your pain at its worst: (Circle only one) No pain 1 2 3 4 5 6 7 8 9 10 Excruciating Pain

Intensity of your pain right now: (Circle only one) No pain 1 2 3 4 5 6 7 8 9 10 Excruciating Pain

How much of the time is this complaint present? (Check only one) ___75-100% ___51-74% ___26-50% ___25% or less

Please describe the character of this complaint (Check all that apply):

___*Soreness* ___*Weakness* ___*Throbbing/Gnawing* ___*Numbness* ___*Achy* ___*Dull*
___*Shooting* ___*Burning* ___*Tingling* ___*Gripping/Constricting* ___*Sharp/stabbing*

What makes your problem <u>better</u>? (Check all that apply):

___*Nothing* ___*Lying Down* ___*Walking* ___ *Standing* ___*Sitting* ___*Movement/Exercise* ___*Inactivity*
___*Bending* ___*Lifting* ___*Pushing/Pulling* ___*Other*_____

What makes your problem <u>worse</u>? (Check all that apply):

___*Nothing* ___*Lying Down* ___*Walking* ___ *Standing* ___*Sitting* ___*Movement/Exercise* ___*Inactivity*
___*Bending* ___*Lifting* ___*Pushing/Pulling* ___*Other*_____

Has this complaint? ___*Gotten worse* ___*Stayed constant* ___*Comes and goes*

Complaint #2:_____ Date of onset:_____ Related to accident/injury? Y / N

If yes, please describe:_____

Intensity of your pain at its worst: (Circle only one) No pain 1 2 3 4 5 6 7 8 9 10 Excruciating Pain

Intensity of your pain right now: (Circle only one) No pain 1 2 3 4 5 6 7 8 9 10 Excruciating Pain

How much of the time is this complaint present? (Check only one) ___75-100% ___51-74% ___26-50% ___25% or less

Please describe the character of this complaint (Check all that apply):

___*Soreness* ___*Weakness* ___*Throbbing/Gnawing* ___*Numbness* ___*Achy* ___*Dull*
___*Shooting* ___*Burning* ___*Tingling* ___*Gripping/Constricting* ___*Sharp/stabbing*

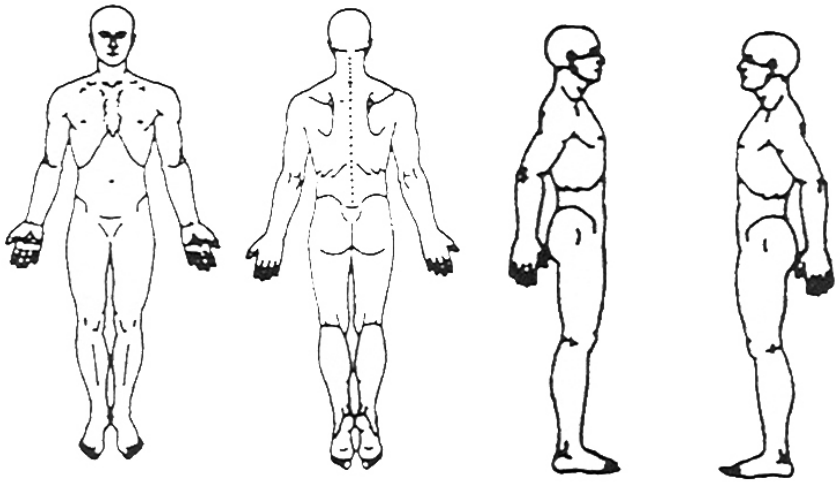
What makes your problem better? (Check all that apply):

___*Nothing* ___*Lying Down* ___*Walking* ___ *Standing* ___*Sitting* ___*Movement/Exercise* ___*Inactivity*
___*Bending* ___*Lifting* ___*Pushing/Pulling* ___*Other*_____

What makes your problem worse? (Check all that apply):

___*Nothing* ___*Lying Down* ___*Walking* ___ *Standing* ___*Sitting* ___*Movement/Exercise* ___*Inactivity*
___*Bending* ___*Lifting* ___*Pushing/Pulling* ___*Other*_____

Has this complaint? ___*Gotten worse* ___*Stayed constant* ___*Comes and goes*



Please mark the body diagrams to the left with the appropriate symbols shown for the type of symptoms experienced due to your conditions/complaints.

= shooting/radiating pain
++ = sharp pain
TT = tingling/pins and needles
BB= burning
XX = dull/achy pain
SS = soreness
NN = numbness

Patient Signature:_____ **Date:**_____