MOVEMENT CLINIC

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Complaint Update

Full Name: ______________________________ **Date:** ________________

Presenting Complaint

Primary complaint: ______________________________

When did your complaint begin? ____________________ **Have you had this complaint before?** ☐ Yes ☐ No

If yes, when? ____________________ **Did you receive treatment?** ☐ Yes ☐ No

If yes, by whom? ____________________ **Outcome?** ____________________

Was the onset: ☐ Gradual ☐ Sudden **Since its onset, has it become:** ☐ Worse ☐ Better ☐ Stayed the same

Describe what caused the pain: ______________________________

Have you tried any self-treatments, taken any medication (over the counter or prescription), or been treated by another Chiropractor or healthcare provider? ☐ Yes ☐ No

If yes, explain: ______________________________

Results: ______________________________

Have you had any X-RAY, MRI, or CT studies? ☐ Yes ☐ No

If yes, date and location: ______________________________

Pain Diagram

Please mark areas of pain using these symbols.

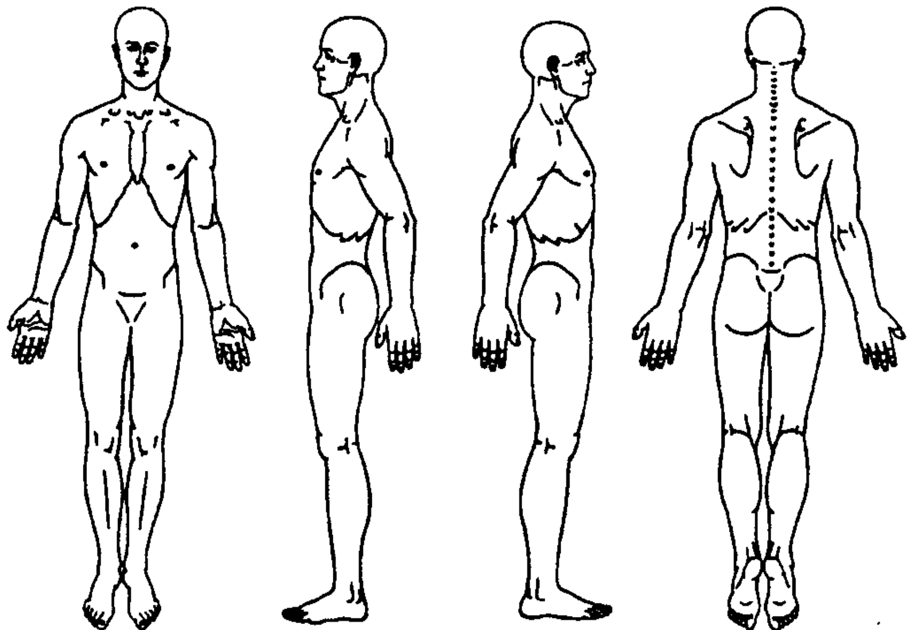
+++ Burning

Dull or Aching

*** Numb or Tingling

=== Throbbing

000 Sharp or Stabbing



Presenting Complaint

List region of pain and circle number which represents intensity of pain at its BEST and WORST on the same line.

Region: ____ **No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable**

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Please indicate the area of complaint you are referring to, if needed. You can mark more than one box and indicate more than one region of complaint.

Describe the quality of the complaint:

- ☐ Burning
- ☐ Cramping
- ☐ Dull ache
- ☐ Giving away
- ☐ Locking/catching
- ☐ Numbness/loss of sensation
- ☐ Popping/grinding
- ☐ Sharp
- ☐ Stabbing
- ☐ Throbbing
- ☐ Tightness/tension
- ☐ Tingling
- ☐ Other: ________________

Describe location of complaint:

- ☐ Very specific area
- ☐ General, localized area
- ☐ Spreads to different area
- ☐ Shoots to different area
- ☐ Other: ________________

How often are you aware of the complaint?

- ☐ Intermittent (0-25% of time)
- ☐ Occasional (25-50% of time)
- ☐ Frequent (50-75% of time)
- ☐ Constant (75-100% of time)

Is your complaint more specific to a time of day?

- ☐ Upon waking
- ☐ In the morning
- ☐ In the afternoon
- ☐ At night
- ☐ No specific time of day

Does your complaint wake you up at night?

- ☐ Yes
- ☐ No

Does complaint interfere with your daily activities?

- ☐ Annoyance, no interference
- ☐ Tolerated, some interference
- ☐ Significant interference
- ☐ Prevents most activity

Please indicate activities that complaint interferes with:

- ☐ Driving
- ☐ Exercise
- ☐ Hobbies
- ☐ Household chores
- ☐ School
- ☐ Sleep
- ☐ Sports
- ☐ Work
- ☐ Other: ________________

How long does complaint typically last?

- ☐ Less than 1 minute
- ☐ Less than 5 minutes
- ☐ Less than 30 minutes
- ☐ Less than 1 hour
- ☐ More than 1 hour
- ☐ Most of the day
- ☐ All day
- ☐ Varies from day to day
- ☐ Other: ________________

Do any of the following make complaints better, even temporarily?

- ☐ Certain position: __________
- ☐ Chiropractic care
- ☐ Exercise
- ☐ Heat
- ☐ Ice
- ☐ Injections
- ☐ Lying down
- ☐ Medication
- ☐ Physical therapy
- ☐ Rest/no movement
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Other: ________________
- ☐ Can't make complaint better

Do any of the following make complaint worse?

- ☐ Bowel movement
- ☐ Cough/sneeze
- ☐ Bending
- ☐ Caring for family
- ☐ Changing positions
- ☐ Driving/riding
- ☐ Getting in/out of car
- ☐ Household chores
- ☐ Lifting
- ☐ Lying down
- ☐ Pulling
- ☐ Pushing
- ☐ Reaching
- ☐ Running
- ☐ Shopping
- ☐ Sitting
- ☐ Sports
- ☐ Squatting
- ☐ Stairs
- ☐ Standing
- ☐ Twisting/turning
- ☐ Walking
- ☐ Working
- ☐ Other: ________________
- ☐ Can't make complaint worse

NOTES

Signed: ____