# MOVEMENT CLINIC

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## Complaint Update and Review of Systems

**Full Name:** _____ **Date:** _____

### Presenting Complaint(s)

**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 provider?** ☐ **Yes** ☐ **No**

**If yes, explain:** _____

**Results:** _____

### Pain Diagram

Please mark areas of pain using these symbols.

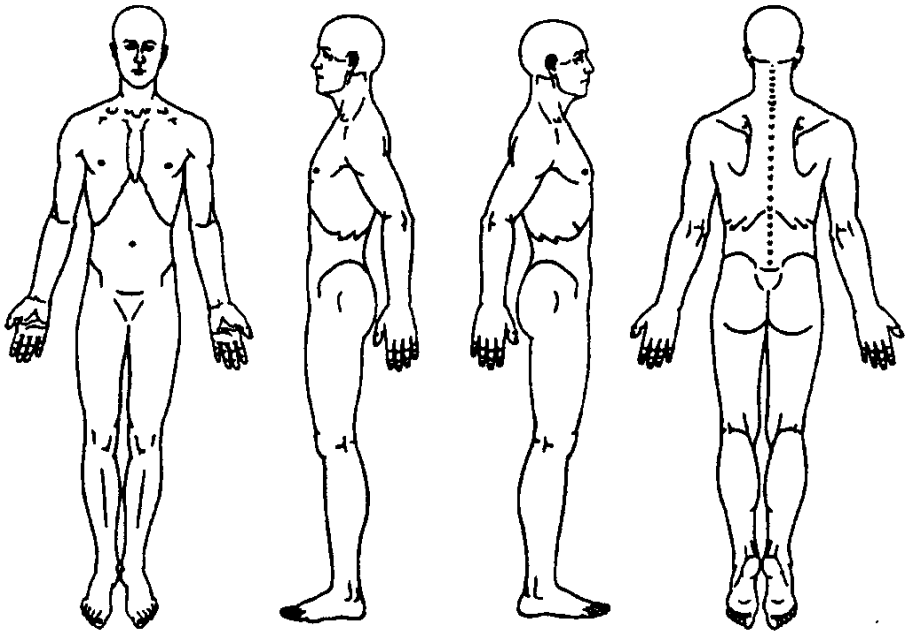
+++ Burning

### Dull or Aching

*** Numb or Tingling

=== Throbbing

000 Sharp or Stabbing



## Presenting Complaint(s) Continued

**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

## Review of Systems

**As you review the following list, please check any problems or conditions that you are CURRENTLY experiencing or have experienced in the 12 MONTHS. If you do not have any of the problems listed, please check NONE.**

### General Health

- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Loss of appetite
- ☐ Night sweats
- ☐ Recent weight gain (6 months)
- ☐ Recent weight loss (6 months)
- ☐ **NONE**

### Endocrine

- ☐ Diabetes (Type I or Type II)
- ☐ Excessive thirst or hunger
- ☐ Frequent urination
- ☐ Heat or cold sensitivity
- ☐ Sweating
- ☐ Thyroid condition: _____
- ☐ **NONE**

### Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Other: _____
- ☐ **NONE**

### Ears, Nose, Mouth, Throat

- ☐ Difficulty swallowing
- ☐ Earaches
- ☐ Loss of hearing
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Painful chewing
- ☐ Ringing in ears
- ☐ Other: _____
- ☐ **NONE**

### Gastrointestinal

- ☐ Abnormal stools
- ☐ Blood in stools
- ☐ Heartburn or indigestion
- ☐ Increasing constipation
- ☐ Nausea
- ☐ Painful bowel movements
- ☐ Persistent diarrhea
- ☐ Stomach or abdominal pain
- ☐ Ulcer
- ☐ Vomiting
- ☐ Other: _____
- ☐ **NONE**

### Respiratory

- ☐ Asthma
- ☐ Chronic or frequent cough
- ☐ Other: _____
- ☐ **NONE**

### Cardiovascular

- ☐ Discoloration of hands or feet
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irregular heartbeat or palpitations
- ☐ Leg pain or cramps with walking
- ☐ Pain in chest
- ☐ Shortness of breath with activity
- ☐ Swelling in hands or feet
- ☐ Other: _____
- ☐ **NONE**

### Hematologic/Lymphatic

- ☐ Bleeding disorder: _____
- ☐ Bruise easily
- ☐ Swollen or enlarged lymph nodes
- ☐ **NONE**

### Eyes

- ☐ Blind spots
- ☐ Blurred vision
- ☐ Double vision
- ☐ Glasses or Contacts
- ☐ Loss of vision
- ☐ Pain
- ☐ **NONE**

### Genitourinary

- ☐ Blood in urine or discoloration
- ☐ Female: irregular bleeding
- ☐ Female: irregular periods
- ☐ Female: menstrual pain
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Male: prostate disease
- ☐ Male: testicle pain or mass
- ☐ Painful or burning urination
- ☐ Sexual difficulty
- ☐ Urgency with urination
- ☐ Urine retention
- ☐ Other: _____
- ☐ **NONE**

### Musculoskeletal

- ☐ Arthritis
- ☐ Difficulty walking
- ☐ Grind or clench teeth
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Joint swelling
- ☐ Limp
- ☐ Muscle cramps
- ☐ Muscle pain or tenderness
- ☐ Other: _____
- ☐ **NONE**

### Neurological

- ☐ Balance trouble
- ☐ Black outs/loss of consciousness
- ☐ Change in handwriting
- ☐ Clumsiness
- ☐ Difficulty speaking
- ☐ Difficulty walking
- ☐ Dizziness
- ☐ Facial drooping
- ☐ Fainting
- ☐ Head injury
- ☐ Headaches
- ☐ Light-headed
- ☐ Memory loss
- ☐ Mental confusion
- ☐ Migraines
- ☐ TIA or Mini stroke
- ☐ Neuropathy
- ☐ Numbness (loss of sensation)
- ☐ Paralysis
- ☐ Stroke
- ☐ Tingling
- ☐ Tremors
- ☐ Vertigo (room spinning)
- ☐ Weakness
- ☐ Other: _____
- ☐ **NONE**

### Skin

- ☐ Breast lump or discharge
- ☐ Color changes
- ☐ Rash
- ☐ Sores or lesions
- ☐ Other: _____
- ☐ **NONE**

## NOTES

**Signed:** _____