

Name: _____ Date: _____

Secondary Complaint & Location

DESCRIBE LOCATION: Sitting here today, right now, what is the intensity of your pain on a scale of 0-10?

_____ (Please circle) 0 1 2 3 4 5 6 7 8 9 10

What is the least intense the symptom has been on a scale of 0-10? 0 1 2 3 4 5 6 7 8 9 10

What is the most intense the symptom has been on a scale of 0-10? 0 1 2 3 4 5 6 7 8 9 10

ASSOCIATED SIGNS AND SYMPTOMS:

How does this symptom affect your movement? Inflexibility Stiffness Spasms Cramps

Other _____

How would you best describe the sensation of the pain/symptom?

- | | | | | |
|--------------------------------|---------------------------------|--------------------------------------|---------------------------------|------------------------------------|
| <input type="radio"/> Deadness | <input type="radio"/> Tingling | <input type="radio"/> Pins & Needles | <input type="radio"/> Throbbing | <input type="radio"/> Aching |
| <input type="radio"/> Prickly | <input type="radio"/> Stabbing | <input type="radio"/> Pounding | <input type="radio"/> Stinging | <input type="radio"/> Excruciating |
| <input type="radio"/> Numb | <input type="radio"/> Hurting | <input type="radio"/> Burning | <input type="radio"/> Dull | |
| <input type="radio"/> Crawling | <input type="radio"/> Pulsating | <input type="radio"/> Shooting | <input type="radio"/> Sharp | |

Over the past several weeks/months this complaint is: Improving Getting worse About the same

Third Complaint & Location

DESCRIBE LOCATION: Sitting here today, right now, what is the intensity of your pain on a scale of 0-10?

_____ (Please circle) 0 1 2 3 4 5 6 7 8 9 10

What is the least intense the symptom has been on a scale of 0-10? 0 1 2 3 4 5 6 7 8 9 10

What is the most intense the symptom has been on a scale of 0-10? 0 1 2 3 4 5 6 7 8 9 10

ASSOCIATED SIGNS AND SYMPTOMS:

How does this symptom affect your movement? Inflexibility Stiffness Spasms Cramps

Other _____

How would you best describe the sensation of the pain/symptom?

- | | | | | |
|--------------------------------|---------------------------------|--------------------------------------|---------------------------------|------------------------------------|
| <input type="radio"/> Deadness | <input type="radio"/> Tingling | <input type="radio"/> Pins & Needles | <input type="radio"/> Throbbing | <input type="radio"/> Aching |
| <input type="radio"/> Prickly | <input type="radio"/> Stabbing | <input type="radio"/> Pounding | <input type="radio"/> Stinging | <input type="radio"/> Excruciating |
| <input type="radio"/> Numb | <input type="radio"/> Hurting | <input type="radio"/> Burning | <input type="radio"/> Dull | |
| <input type="radio"/> Crawling | <input type="radio"/> Pulsating | <input type="radio"/> Shooting | <input type="radio"/> Sharp | |

Over the past several weeks/months this complaint is: Improving Getting worse About the same

DOCTOR'S NOTES: _____
