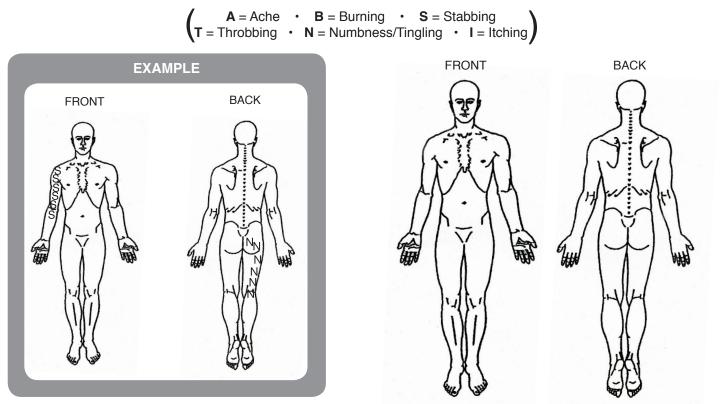
Name:		M/F Age:	Height:	Wt.:	Date:
Complaints in	1)				
order of severity/	2)				
importance	3)				

SPECIFICS FOR COMPLAINT #1

(As it feels lately, during the past few days)

Mark the location and quality of the discomfort/pain on the diagram below:



At the time of the day below rate the level of your discomfort/pain on a scale of 1 to 10, with 1 being barely noticable and 10 being so severe that you could only stand it for a few seconds:

Upong awakening and first getting out of bed:_____ In the mid-day: _____ In the evening (before bed): _____ At night (while trying to sleep): _____

How does complaint #1 currently interfere with your life and ability to function? (If it doesn't apply then don't mark anything)

Sitting	No Affect	Mild Affect	Moderate Affect	Severe Affect
Sitting				0
Rising out of a chair				0
Standing				———————————————————————————————————————
Walking			0	———————————————————————————————————————
Lying down		O		———————————————————————————————————————
Bending over		O		———————————————————————————————————————
Climbing stairs		O		———————————————————————————————————————
Using a computer		O		———————————————————————————————————————
Getting in/out of a car				———————————————————————————————————————
Driving a car				0
Caring for family				———————————————————————————————————————

	No Affect	Mild Affect	Moderate Affect	Severe Affect
Grocery shopping				0
Household chores				0
Lifting objects				0
Reaching overhead				0
Showering or Bathing —				0
Dressing myself				0
Love life				0
Getting to sleep				0
Staying asleep				0
Concentrating			0	0
Yard work				0

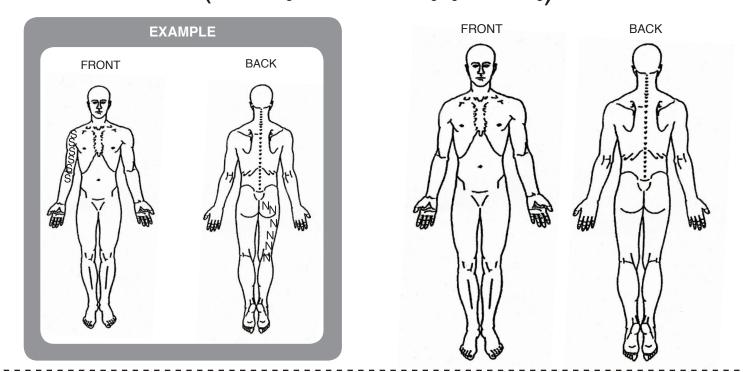
_ _ _ _ _ _ _ _ _ _

SPECIFICS FOR COMPLAINT #2

(As it feels lately, during the past few days)

Mark the location and qaulity of the discomfort/pain on the diagram below:

$$\begin{pmatrix} A = Ache & \cdot & B = Burning & \cdot & S = Stabbing \\ T = Throbbing & \cdot & N = Numbness/Tingling & \cdot & I = Itching \end{pmatrix}$$



At the time of the day below rate the level of your discomfort/pain on a scale of 1 to 10, with 1 being barely noticable and 10 being so severe that you could only stand it for a few seconds:

Upong awakening and first getting out of bed:_____ In the mid-day: _____ In the evening (before bed): _____ At night (while trying to sleep): _____

How does complaint #2 currently interfere with your life and ability to function? (If it doesn't apply then don't mark anything)

Sitting	No Affect	Mild Affect	Moderate Affect	Severe Affect	Grocery shopping	No Affect	Mild Affect	Moderate Affect	Severe Affect
0		()		0		0	0	0	0
Rising out of a chair——	O	O	O	O	Household chores ———	O	O		0
Standing —				0	Lifting objects				0
Walking				0	Reaching overhead				0
Lying down				0	Showering or Bathing —				0
Bending over				0	Dressing myself				0
Climbing stairs				0	Love life				0
Using a computer				0	Getting to sleep				0
Getting in/out of a car				0	Staying asleep				0
Driving a car ———				0	Concentrating				0
Caring for family				0	Yard work	O			0

ADDITIONAL INFORMATION ABOUT EITHER COMPLAINT WHICH MAYBE HELPFUL:

(Please specify in your comments whether it is complaint #1, #2, or #3 you are referring to):