Name:______________________________ M/F Age:________ Height: ________Wt.: ________ Date: _____________

Complaints in order of severity/ importance

1)____

2)____

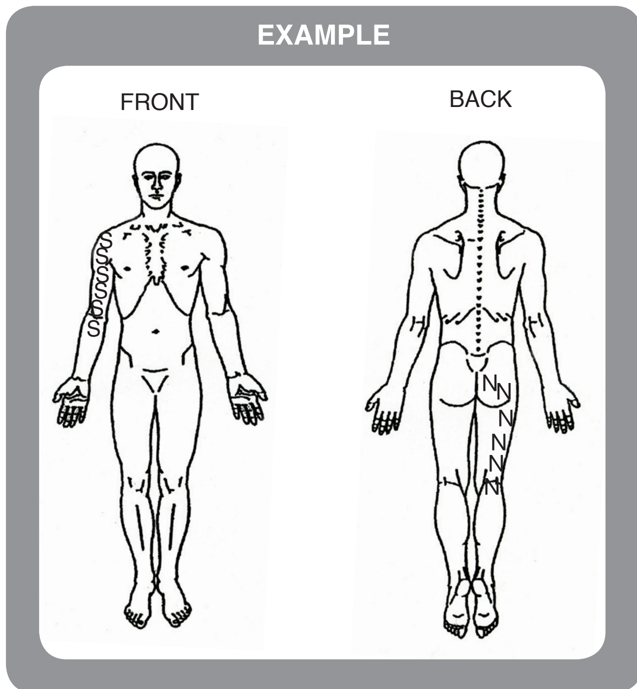
3)____

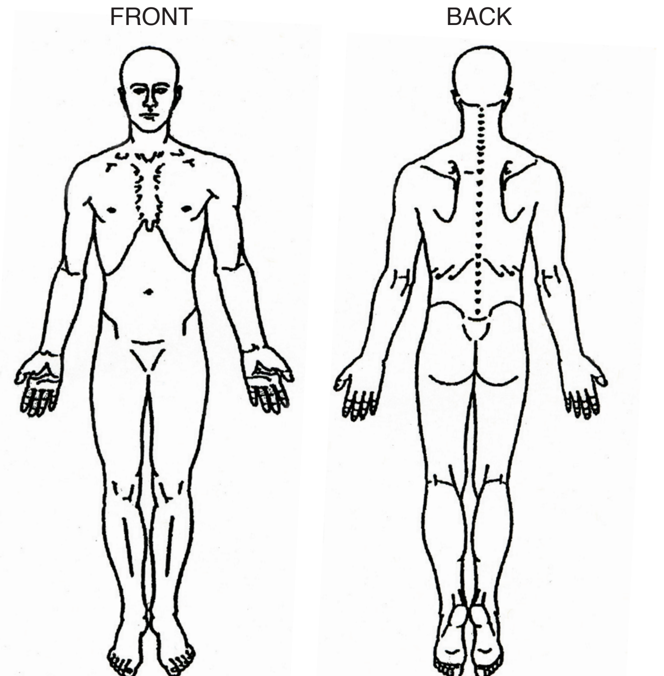
SPECIFICS FOR COMPLAINT #1

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

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

(**A** = Ache • **B** = Burning • **S** = Stabbing
T = Throbbing • **N** = Numbness/Tingling • **I** = Itching)





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)*

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

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

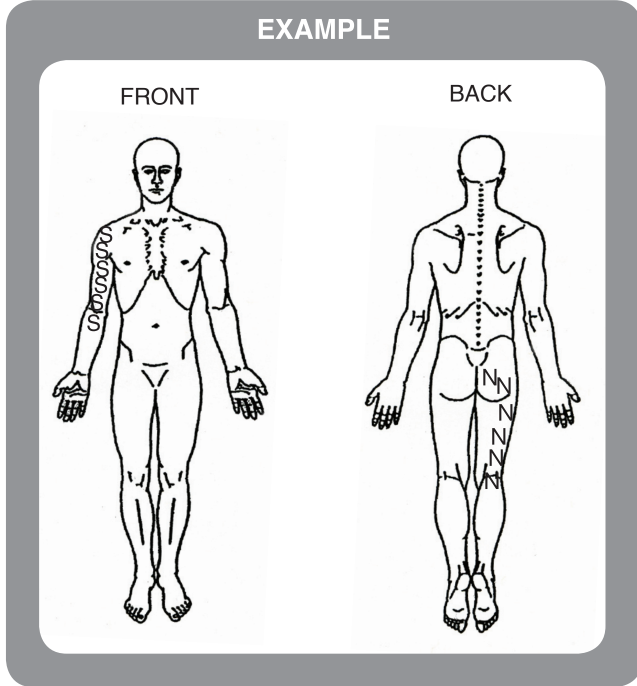
Name:____________________________________ Date: _____________

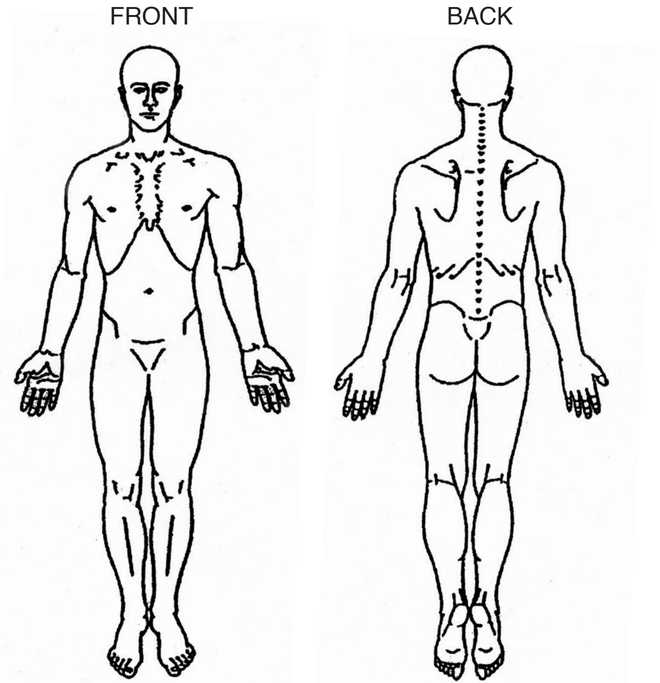
SPECIFICS FOR COMPLAINT #2

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

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

(**A** = Ache • **B** = Burning • **S** = Stabbing
T = Throbbing • **N** = Numbness/Tingling • **I** = Itching)





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)*

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

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

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):

____
____
____
____