Name: ______________________ Date: ______________

COMPLAINT Choose area effected or write in complaint.	CAUSE What were you doing when the pain started?	HOW LONG Have you had the pain?	CIRCLE How the pain feels.	AGGRAVATES What do you do that makes the pain worse?	RELIEVES What do you do that makes the pain better?	RADIATING Does the pain extend beyond one area?
HEADACHES			Dull Sharp/Stabbing Throbbing Burning Numb			
Rate your pain: none 1 2 3 4 5 6 7 8 9 10 severe						
NECK PAIN			Dull Sharp/Stabbing Throbbing Burning Numb			
Rate your pain: none 1 2 3 4 5 6 7 8 9 10 severe						
MID-UPPER BACK PAIN			Dull Sharp/Stabbing Throbbing Burning Numb			
Rate your pain: none 1 2 3 4 5 6 7 8 9 10 severe						
LOW BACK PAIN			Dull Sharp/Stabbing Throbbing Burning Numb			
Rate your pain: none 1 2 3 4 5 6 7 8 9 10 severe						
			Dull Sharp/Stabbing Throbbing Burning Numb			
Rate your pain: none 1 2 3 4 5 6 7 8 9 10 severe						

Please draw in the area(s) of pain on the pictures provided to the right.

Height: ______________

Weight: ______________

How much have your symptoms interfered with your usual daily activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

In what way has your condition affected your life? (Family/Professional)

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