Active Health Chiropractic & Therapy
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Austin, Texas 78759
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CHIEF COMPLAINT WORKSHEET

Describe your complaint(s) and what happened in your own words (please specific)

_____

_____

When did symptoms start? _____ Symptoms are getting? Better / Worse / Not Changing

Does the pain radiate/travel? Yes / No Are you experiencing tingling or numbness? Yes / No

How often do you experience symptoms (circle)?
Constantly (76-100% of the day) Occasionally (26-50% of the day)
Frequently (51-75% of the day) Intermittently (0-25% of the day)

Describe the nature of your symptoms (circle all that apply)?
Sharp Dull Ache Numb Shooting Burning Tingling

Aggravating factors? _____ Relief Factors? _____

What home/work/social activities does it interfere with? _____

Does the complaint/pain keep you awake at night? Yes / No

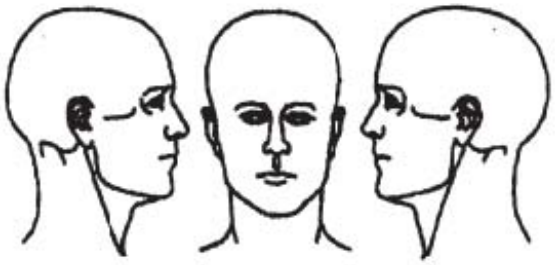
This condition is the result of (circle): Accident / Auto Accident / On the Job Injury / Repetitive Usage / Other

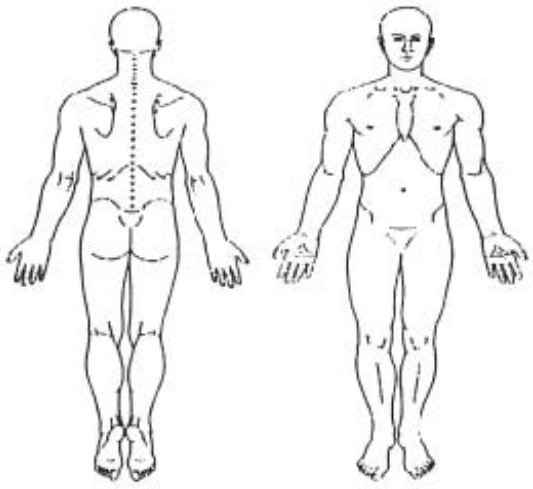
Who else have you seen for this condition and what diagnostic tests/treatments were performed?

_____

Rate the average severity of your condition:
(0 being no pain) 0 1 2 3 4 5 6 7 8 9 10 (10 being worst)

Use the diagram and symbols to demonstrate the location and type of pain.
(Mark **X** for pain, **O** for numbness, **//** for tingling)





Are you having trouble?

- ☐ Bending
- ☐ Driving
- ☐ Lifting
- ☐ Sitting
- ☐ Sleeping
- ☐ Standing
- ☐ Walking
- ☐ _____

Signature (Guardian if under 18): _____ Date: _____