

Name: _____

Today's Date: _____

List your Pains/Complaints from Most Severe (1) to Least Severe (4)

Chief Complaints:	1.	2.	3.	4.
Is this complaint:	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Numb <input type="checkbox"/> Electric / Shooting	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Numb <input type="checkbox"/> Electric / Shooting	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Numb <input type="checkbox"/> Electric / Shooting	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Numb <input type="checkbox"/> Electric / Shooting
How often do you feel this Complaint?	<input type="checkbox"/> Constant <input type="checkbox"/> Daily <input type="checkbox"/> Off & On <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____	<input type="checkbox"/> Constant <input type="checkbox"/> Daily <input type="checkbox"/> Off & On <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____	<input type="checkbox"/> Constant <input type="checkbox"/> Daily <input type="checkbox"/> Off & On <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____	<input type="checkbox"/> Constant <input type="checkbox"/> Daily <input type="checkbox"/> Off & On <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____
How did it happen?	_____	_____	_____	_____
How long have you had this complaint?	_____	_____	_____	_____
Is it getting better, worse, or staying the same?	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same
What makes it better?	_____	_____	_____	_____
What makes it worse?	_____	_____	_____	_____
On a scale of 1 to 10 Rate your discomfort.	<u>Circle one:</u> 1 2 3 4 5 6 7 8 9 10 10 = Excruciating 0 = No discomfort	<u>Circle one:</u> 1 2 3 4 5 6 7 8 9 10 10 = Excruciating 0 = No discomfort	<u>Circle one:</u> 1 2 3 4 5 6 7 8 9 10 10 = Excruciating 0 = No discomfort	<u>Circle one:</u> 1 2 3 4 5 6 7 8 9 10 10 = Excruciating 0 = No discomfort
How have you taken care of this in the past? How has it worked for you?	_____	_____	_____	_____
This issue is affecting my:	<input type="checkbox"/> Job <input type="checkbox"/> Childcare <input type="checkbox"/> Marriage <input type="checkbox"/> Sex <input type="checkbox"/> Golf <input type="checkbox"/> Finances <input type="checkbox"/> Playing with Kids <input type="checkbox"/> Bowels <input type="checkbox"/> Urine	<input type="checkbox"/> Job <input type="checkbox"/> Childcare <input type="checkbox"/> Marriage <input type="checkbox"/> Sex <input type="checkbox"/> Golf <input type="checkbox"/> Finances <input type="checkbox"/> Playing with Kids <input type="checkbox"/> Bowels <input type="checkbox"/> Urine	<input type="checkbox"/> Job <input type="checkbox"/> Childcare <input type="checkbox"/> Marriage <input type="checkbox"/> Sex <input type="checkbox"/> Golf <input type="checkbox"/> Finances <input type="checkbox"/> Playing with Kids <input type="checkbox"/> Bowels <input type="checkbox"/> Urine	<input type="checkbox"/> Job <input type="checkbox"/> Childcare <input type="checkbox"/> Marriage <input type="checkbox"/> Sex <input type="checkbox"/> Golf <input type="checkbox"/> Finances <input type="checkbox"/> Playing with Kids <input type="checkbox"/> Bowels <input type="checkbox"/> Urine
Helping this issue would increase my Quality of life by:	<input type="checkbox"/> 10-20% <input type="checkbox"/> 30-40% <input type="checkbox"/> 50-60% <input type="checkbox"/> 70-80% <input type="checkbox"/> 90% <input type="checkbox"/> 100%	<input type="checkbox"/> 10-20% <input type="checkbox"/> 30-40% <input type="checkbox"/> 50-60% <input type="checkbox"/> 70-80% <input type="checkbox"/> 90% <input type="checkbox"/> 100%	<input type="checkbox"/> 10-20% <input type="checkbox"/> 30-40% <input type="checkbox"/> 50-60% <input type="checkbox"/> 70-80% <input type="checkbox"/> 90% <input type="checkbox"/> 100%	<input type="checkbox"/> 10-20% <input type="checkbox"/> 30-40% <input type="checkbox"/> 50-60% <input type="checkbox"/> 70-80% <input type="checkbox"/> 90% <input type="checkbox"/> 100%