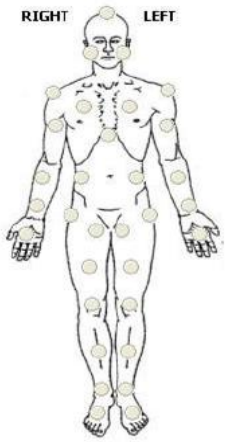
Complaint Form
(Initial Exam, Follow-Up/Final Exam, Daily Note)

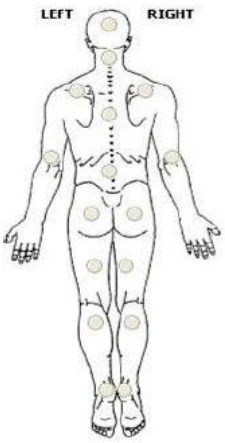
LAST NAME: _____ FIRST NAME: _____ DATE: _____

Place an X the part(s) of the body where you are experiencing pain or discomfort and grade your pain level on a scale of 0-10 with 10 being the worst.

Please grade pain 0-10 (10 is the highest) ⓿ ❶ ❷ ❸ ❹ ❺ ❻ ❼ ❽ ❾ ❿



Other: _____



This complaint came on:	☐ Gradually	☐ Immediately		
It is getting:	☐ Better	☐ Same	☐ Worse	
The intensity is:	☐ Minimal	☐ Slight	☐ Moderate	☐ Severe
The frequency is:	☐ Occasional	☐ Frequent	☐ Constant	
The pain is:	☐ Dull	☐ Sharp	☐ Aching	☐ Shooting
	☐ Spasm	☐ Throbbing	☐ Burning	☐ Numb
	☐ Tingling	☐ Other: _____		
The pain is on the:	☐ Left side	☐ Right Side	☐ Bilateral	

Please mark the actions affecting your complaint(s): **Other: _____**

Morning	☐ Brings on	☐ Aggravates	☐ Relieves
Afternoon	☐ Brings on	☐ Aggravates	☐ Relieves
Bending forward	☐ Brings on	☐ Aggravates	☐ Relieves
Bending back	☐ Brings on	☐ Aggravates	☐ Relieves
Bending left	☐ Brings on	☐ Aggravates	☐ Relieves
Bending right	☐ Brings on	☐ Aggravates	☐ Relieves
Twisting left	☐ Brings on	☐ Aggravates	☐ Relieves
Twisting right	☐ Brings on	☐ Aggravates	☐ Relieves
Coughing	☐ Brings on	☐ Aggravates	☐ Relieves
Sneezing	☐ Brings on	☐ Aggravates	☐ Relieves
Straining	☐ Brings on	☐ Aggravates	☐ Relieves
Standing	☐ Brings on	☐ Aggravates	☐ Relieves
Lifting	☐ Brings on	☐ Aggravates	☐ Relieves
Sitting	☐ Brings on	☐ Aggravates	☐ Relieves
Heat	☐ Brings on	☐ Aggravates	☐ Relieves
Cold	☐ Brings on	☐ Aggravates	☐ Relieves
Rest	☐ Brings on	☐ Aggravates	☐ Relieves
Laying down	☐ Brings on	☐ Aggravates	☐ Relieves
Medications	☐ Brings on	☐ Aggravates	☐ Relieves

PAIN DISABILITY QUESTIONNAIRE

LAST NAME: _____ FIRST NAME: _____ DATE: _____

Complete this questionnaire if you're experiencing any pain/discomfort. Rate the degree to which your symptoms over the past month have negatively affected your ability to perform the following functions. Rate each function as follows: 0 not at all, 1 – 3 slightly, 4 – 6 moderately, 7 – 10 severely.

1. Does your pain interfere with your normal work inside and outside the home?

Work Normally — Unable to work at all

0 1 2 3 4 5 6 7 8 9 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?

Take care of myself completely — Need help with all my personal care

0 1 2 3 4 5 6 7 8 9 10

3. **Does your pain interfere with traveling**?

Travel anywhere I like — Only travel to see doctors

0 1 2 3 4 5 6 7 8 9 10

4. Does your pain affect your ability to sit or stand?

No problems — Not sit/stand at all

0 1 2 3 4 5 6 7 8 9 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?

No problems — Cannot do at all

0 1 2 3 4 5 6 7 8 9 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?

No problems — Cannot do at all

0 1 2 3 4 5 6 7 8 9 10

7. Does your pain affect your ability to walk or run?

No problems — Cannot walk/run at all

0 1 2 3 4 5 6 7 8 9 10

8. Has your income decreased since your pain began?

No decline — Lost all income

0 1 2 3 4 5 6 7 8 9 10

9. Do you have to take pain medication every day to control your pain?

No medication needed — On pain medication throughout the day

0 1 2 3 4 5 6 7 8 9 10

10. Does your pain force you to see doctors much more than before your pain began?

Never see doctors — See doctors weekly

0 1 2 3 4 5 6 7 8 9 10

11. Does your pain interfere with your ability to see people who are important to you as much as you would like?

No problems — Never see them

0 1 2 3 4 5 6 7 8 9 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?

No interference — Total interference

0 1 2 3 4 5 6 7 8 9 10

13. Do you need help of your family and friends to complete everyday tasks (including both work outside home and housework) because of your pain?

Never need help — Need help all the time

0 1 2 3 4 5 6 7 8 9 10

14. Do you feel now more depressed, tense, or anxious than before your pain began?

No depression/tension — Severe depression/tension

0 1 2 3 4 5 6 7 8 9 10

15. Are there emotional problems caused by your pain that interfere with your family, social, and/or work activities?

No problems — Severe problems

0 1 2 3 4 5 6 7 8 9 10