



SUBJECTIVE COMPLAINT

YOUR NAME: _____ Date ____/____/____

Is the complaint a result of a(n): Injury Auto accident Work-related accident Other

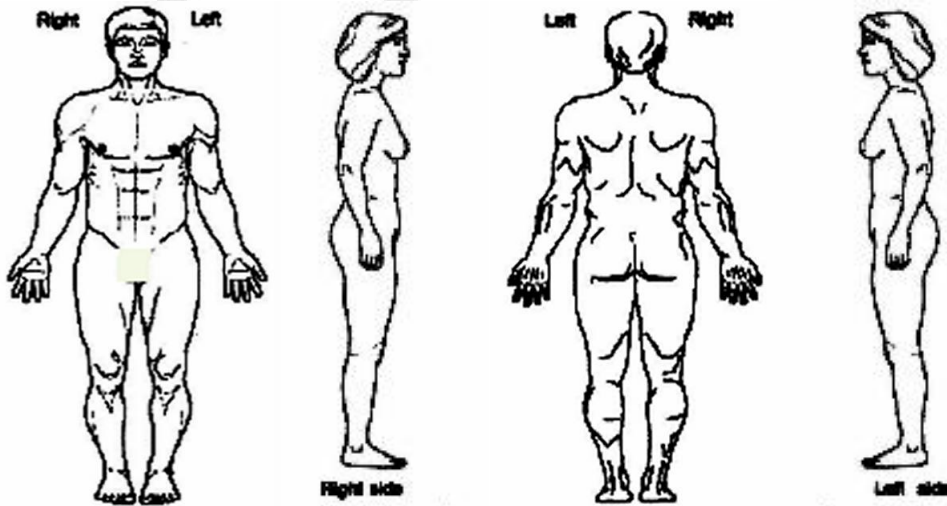
When did it first happen? _____

How did it happen? _____

Did you miss work? No Yes (from ____/____/____ to ____/____/____)

Were you hospitalized? No Yes (from ____/____/____ to ____/____/____)

Mark in the areas of discomfort in the pictures below:



KEY

- NN = Numbness
- PP = Pins & needles
- BB = Burning
- AA = Aching
- SS = Sharp & Stabbing

Are you:

- Right handed?
- Left handed?

Please make a mark on the pain scale, indicating the pain you feel with this condition (10 being the worst pain you can imagine, 0 being no pain)

0 _____ 10

Current Health Status: Great Good Fair Poor Unhappy with health?

Do you have a blood relative with a major disease?
(i.e. Heart disease, Stroke, High blood pressure, Cancer, Diabetes...)

Relation:

Disease

Age

Alive

_____ Yes / No

_____ Yes / No

_____ Yes / No

_____ Yes / No

Date: _____ Patient's Signature: _____