

## Description of Symptoms

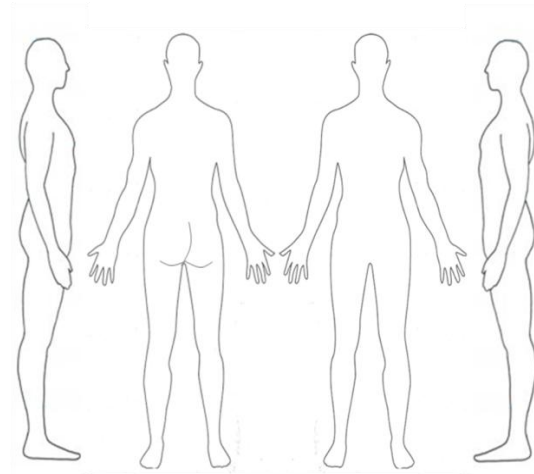
Describe only your **WORST** symptom, or chief complaint, on this page. Additional complaints can be entered on the following pages.

A) **FIRST Current Symptoms:** (Please check off the boxes in the sections below to describe your one WORST symptom)

### 1) Check only ONE body location below

Choose One:	Left	Right	Both
<input type="checkbox"/> Jaw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mid Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Low Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ribs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Buttocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Forearm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Front <input type="checkbox"/> Top <input type="checkbox"/> Back of head			
<input type="checkbox"/> Other locations: _____			

Indicate on the drawing below the location of your WORST complaint only



### 2) Types of pain

<input type="checkbox"/> Dull	<input type="checkbox"/> Sharp	<input type="checkbox"/> Aching	<input type="checkbox"/> Cutting
<input type="checkbox"/> Throbbing	<input type="checkbox"/> Burning	<input type="checkbox"/> Numbing	<input type="checkbox"/> Tingling
<input type="checkbox"/> Spasm	<input type="checkbox"/> Stinging	<input type="checkbox"/> Shooting	<input type="checkbox"/> Pounding
<input type="checkbox"/> Cramping	<input type="checkbox"/> Constricting		

Other types of pain: \_\_\_\_\_

### 6) Actions affecting this pain

	Brings On	Aggravates	Relieves
<input type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Actions:			
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 3) Pain Frequency

<input type="checkbox"/> Up to ¼ of awake time	<input type="checkbox"/> ¼ to ½ of time
<input type="checkbox"/> ½ to ¾ of awake time	<input type="checkbox"/> Most all the time

### 4) Pain Intensity (How it affects daily activities)

<input type="checkbox"/> Doesn't affect	<input type="checkbox"/> Somewhat affects
<input type="checkbox"/> Seriously affects	<input type="checkbox"/> Prevents activities

### 5) Does this pain radiate other body parts?

	Left	Right	Both
<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other locations of radiation: \_\_\_\_\_

# Description of Symptoms

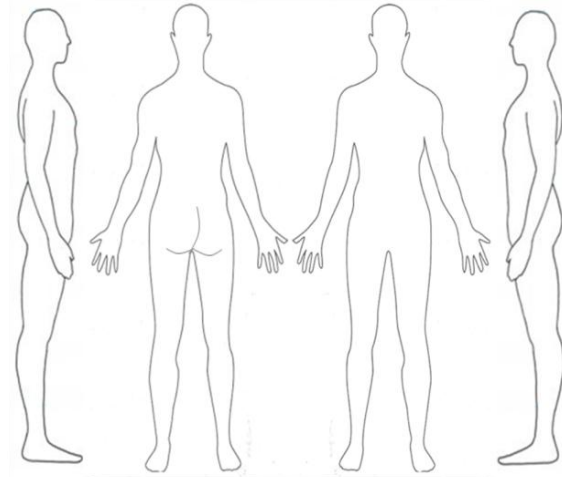
Describe only your **SECOND** symptom, or chief complaint, on this page. Additional complaints can be entered on the following pages.

B) SECOND Current Symptoms: (Please check off the boxes in the sections below to describe your one SECOND symptom)

**1) Check only ONE body location below**

Choose One:	Left	Right	Both
<input type="checkbox"/> Jaw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mid Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Low Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ribs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Buttocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Forearm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Front <input type="checkbox"/> Top <input type="checkbox"/> Back of head			
<input type="checkbox"/> Other locations: _____			

**Indicate on the drawing below the location of your SECOND complaint only**



**2) Types of pain**

<input type="checkbox"/> Dull	<input type="checkbox"/> Sharp	<input type="checkbox"/> Aching	<input type="checkbox"/> Cutting
<input type="checkbox"/> Throbbing	<input type="checkbox"/> Burning	<input type="checkbox"/> Numbing	<input type="checkbox"/> Tingling
<input type="checkbox"/> Spasm	<input type="checkbox"/> Stinging	<input type="checkbox"/> Shooting	<input type="checkbox"/> Pounding
<input type="checkbox"/> Cramping	<input type="checkbox"/> Constricting		

Other types of pain: \_\_\_\_\_

**6) Actions affecting this pain**

	Brings On	Aggravates	Relieves
<input type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Actions:			
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**3) Pain Frequency**

<input type="checkbox"/> Up to ¼ of awake time	<input type="checkbox"/> ¼ to ½ of time
<input type="checkbox"/> ½ to ¾ of awake time	<input type="checkbox"/> Most all the time

**4) Pain Intensity (How it affects daily activities)**

<input type="checkbox"/> Doesn't affect	<input type="checkbox"/> Somewhat affects
<input type="checkbox"/> Seriously affects	<input type="checkbox"/> Prevents activities

**5) Does this pain radiate other body parts?**

	Left	Right	Both
<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other locations of radiation: _____			

## Description of Symptoms

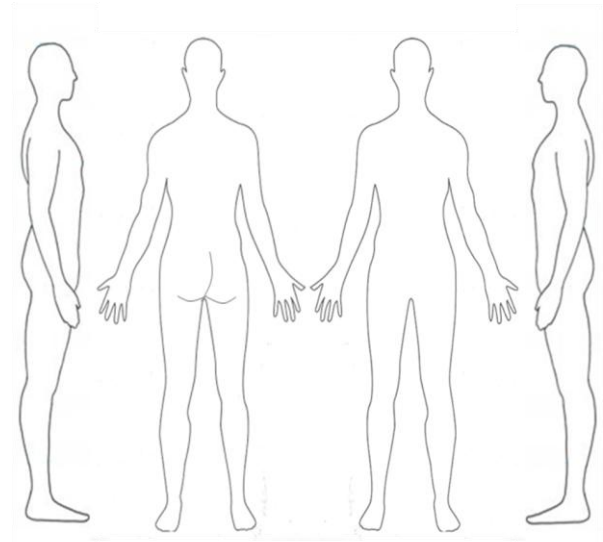
Describe only your **THIRD** symptom, or chief complaint, on this page. Additional complaints can be entered on the following pages.

C) **THIRD Current Symptoms:** (Please check off the boxes in the sections below to describe your one THIRD symptom)

**6) Check only ONE body location below**

Choose One:	Left	Right	Both
<input type="checkbox"/> Jaw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mid Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Low Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ribs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Buttocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Forearm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Front <input type="checkbox"/> Top <input type="checkbox"/> Back			
<input type="checkbox"/> Other locations: _____			

**Indicate on the drawing below the location of your THIRD complaint only**



**7) Types of pain**

<input type="checkbox"/> Dull	<input type="checkbox"/> Sharp	<input type="checkbox"/> Aching	<input type="checkbox"/> Cutting
<input type="checkbox"/> Throbbing	<input type="checkbox"/> Burning	<input type="checkbox"/> Numbing	<input type="checkbox"/> Tingling
<input type="checkbox"/> Spasm	<input type="checkbox"/> Stinging	<input type="checkbox"/> Shooting	<input type="checkbox"/> Pounding
<input type="checkbox"/> Cramping	<input type="checkbox"/> Constricting		

Other types of pain: \_\_\_\_\_

**6) Actions affecting this pain**

	Brings On	Aggravates	Relieves
<input type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Actions: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**8) Pain Frequency**

<input type="checkbox"/> Up to ¼ of awake time	<input type="checkbox"/> ¼ to ½ of time
<input type="checkbox"/> ½ to ¾ of awake time	<input type="checkbox"/> Most all the time

**9) Pain Intensity (How it affects daily activities)**

<input type="checkbox"/> Doesn't affect	<input type="checkbox"/> Somewhat affects
<input type="checkbox"/> Seriously affects	<input type="checkbox"/> Prevents activities

**10) Does this pain radiate other body parts?**

	Left	Right	Both
<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other locations of radiation: _____			