

GARDINER FAMILY CHIROPRACTIC
COMPLAINT FORM Side 1 of 2

Full Name: _____

Date: _____

Office Use Only: New Patient New Injury New Area of Complaint Follow-Up / Aggravation

Chief Complaint: _____ Date of onset: _____ Related to accident/injury? yes no

If yes, please describe: _____

Intensity of your pain: (Circle only **one**) No Pain 1 2 3 4 5 6 7 8 9 10 Excruciating Pain

How much of the time is this complaint present? (Check only **one**) 75-100% 51-74% 26-50% 25% or less

Please describe the character of this complaint (Check all that apply): Sharp/stabbing Achy Dull

Soreness Weakness Throbbing/Gnawing Numbness Shooting Gripping/Constricting Burning Tingling

What makes your problem better? (Check all that apply):

Nothing Lying down Walking Standing Sitting Movement/Exercise

Inactivity Bending Lifting Pushing/Pulling Other _____

What makes your problem worse? (Check all that apply):

Nothing Lying down Walking Standing Sitting Movement/Exercise

Inactivity Bending Lifting Pushing/Pulling Other _____

Has this complaint? Gotten worse Stayed Constant Comes and Goes

Does this complaint interfere with? (Check all that apply) Work Sleep Daily routine Other activities

Complaint #2: _____ Date of onset: _____ Related to accident/injury? yes no

If yes, please describe: _____

Intensity of your pain: (Circle only **one**) No Pain 1 2 3 4 5 6 7 8 9 10 Excruciating Pain

How much of the time is this complaint present? (Check only **one**) 75-100% 51-74% 26-50% 25% or less

Please describe the character of this complaint (Check all that apply): Sharp/stabbing Achy Dull

Soreness Weakness Throbbing/Gnawing Numbness Shooting Gripping/Constricting Burning Tingling

What makes your problem better? (Check all that apply):

Nothing Lying down Walking Standing Sitting Movement/Exercise

Inactivity Bending Lifting Pushing/Pulling Other _____

What makes your problem worse? (Check all that apply):

Nothing Lying down Walking Standing Sitting Movement/Exercise

Inactivity Bending Lifting Pushing/Pulling Other _____

Has this complaint? Gotten worse Stayed Constant Comes and Goes

Does this complaint interfere with? (Check all that apply) Work Sleep Daily routine Other activities

Complaint #3: _____ Date of onset: _____ Related to accident/injury? yes no

If yes, please describe: _____

Intensity of your pain: (Circle only **one**) No Pain 1 2 3 4 5 6 7 8 9 10 Excruciating Pain

How much of the time is this complaint present? (Check only **one**) 75-100% 51-74% 26-50% 25% or less

Please describe the character of this complaint (Check all that apply): Sharp/stabbing Achy Dull

Soreness Weakness Throbbing/Gnawing Numbness Shooting Gripping/Constricting Burning Tingling

What makes your problem better? (Check all that apply):

Nothing Lying down Walking Standing Sitting Movement/Exercise

Inactivity Bending Lifting Pushing/Pulling Other _____

What makes your problem worse? (Check all that apply):

Nothing Lying down Walking Standing Sitting Movement/Exercise

Inactivity Bending Lifting Pushing/Pulling Other _____

Has this complaint? Gotten worse Stayed Constant Comes and Goes

Does this complaint interfere with? (Check all that apply) Work Sleep Daily routine Other activities

PLEASE COMPLETE BOTH SIDES OF THIS FORM