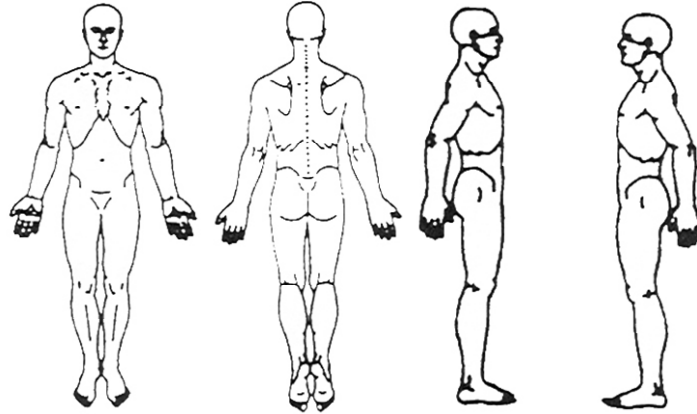


**GARDINER FAMILY CHIROPRACTIC
COMPLAINT FORM Side 2 of 2**

Full Name: _____

Date: _____

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



Please mark the body diagrams to the left with the appropriate symbols shown for the type of symptoms experienced due to your conditions/complaints:

- ## = shooting/radiating pain
- ++ = sharp pain
- TT = tingling/pins and needles
- BB = burning
- XX = dull/achy pain
- SS = soreness
- NN = numbness

This section to be completed by all patients:

Medication you are presently taking

What condition are you taking this medication for?

Medication you are presently taking	What condition are you taking this medication for?

Are you currently receiving other therapy? Yes No

If yes, by: (Check all that apply) Over the counter medications Anti-inflammatories Muscle relaxers
 Physical therapy from a PT Other: _____

How would you grade your general stress level? (Check **one**) None Minimal Moderate Greatly Stressed

General physical activity: (Check **one**) No regular exercise Light exercise Moderate exercise Strenuous exercise

Physical activity at work: (Check **one**) Sitting more than 50% of workday Light manual labor
 Manual labor Heavy manual labor

Are your complaints affecting your ability to be active? (Check **one**)

No effect Some physical restrictions (able to perform light duties) Need limited assistance with everyday tasks
 Need assistance often Have a significant inability to function w/o assistance Am totally disabled, cannot care for myself

What activities have you been unable to perform due to your complaints? _____

Has your weight recently changed by more than 10 pounds? No Gain Loss

This section to be completed by patients receiving a follow-up examination or experiencing an aggravation.

Check the most appropriate description for the status of your original complaints:

much better slightly better about the same slightly worse much worse

Please describe any trauma (e.g. falls, injuries) since your last evaluation that may have caused aggravation to your original complaints:

None, that I can recall. Yes, I had an aggravation of my condition on (date): _____

If yes, describe: _____

How would you rate your satisfaction with the treatment received to date? Very pleased Pleased Somewhat Lacking

I would appreciate further information/I have additional questions concerning: _____

I have a new concern regarding: _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Patient Signature _____ Date _____