Please fill out this form with your symptoms you are experiencing today

Patient Name: ____________________________ Chart#: _____________ Date: ___________

Subjective Complaints:

Head __________________________________

( ) Headache
Same Better Worse
Pain Level _________ (0-10)
( ) Dizziness
( ) Light-headed
( ) Memory Loss
( ) Tinnitus
( ) Visual Disturbance

Neck ____________________________________

( ) Neck Pain
Same Better Worse
Pain Level________ (0-10)
( ) Spasm
( ) Tightness/Stiffness
( ) Ref. Arm: RT LT Both
( ) Weakness in arm: RT LT Both
( ) Numbness in arm: RT LT Both

Mid Back ________________________________

( ) Mid back pain
Same Better Worse
Pain level _______ (0-10)
( ) Spasm
( ) Tightness or Stiffness
( ) Right side pain
( ) Left side pain
( ) Rib pain: RT LT Both

Low Back __________________________________

( ) Low back pain
Same Better Worse
Pain level _______ (0-10)
( ) Spasm
( ) Tightness or Stiffness
( ) Ref. Leg: RT LT Both
( ) Weakness in leg: RT LT Both
( ) Numbness in leg: RT LT Both

Please list any other symptoms:

Please explain what caused your pain and when it happened: