

PATIENT NAME: _____

DATE: _____

PATIENT SYMPTOMS

Describe your symptoms in the sections below in order of severity

MAIN COMPLAINT: CHECK BOX that describes your **FIRST COMPLAINT** and **ONLY ONE** complaint per section.

1. Check ONLY ONE AREA		2. Types of Pain (check ALL that apply)			Other type of Pain																																																														
L = left R = Right B = Both		<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"/> Cramping <input type="checkbox"/> Spasm <input type="checkbox"/> Stinging <input type="checkbox"/> Shooting <input type="checkbox"/> Pounding <input type="checkbox"/> Constricting			_____																																																														
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SECONDARY COMPLAINT: CHECK BOX that describes your **NEXT COMPLAINT** and **ONLY ONE** complaint per section.

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PLEASE CONTINUE ON BACK

