ChiroCenter One

Present Complaint Questionnaire

Name _____ Date ____/____/____ File # _____

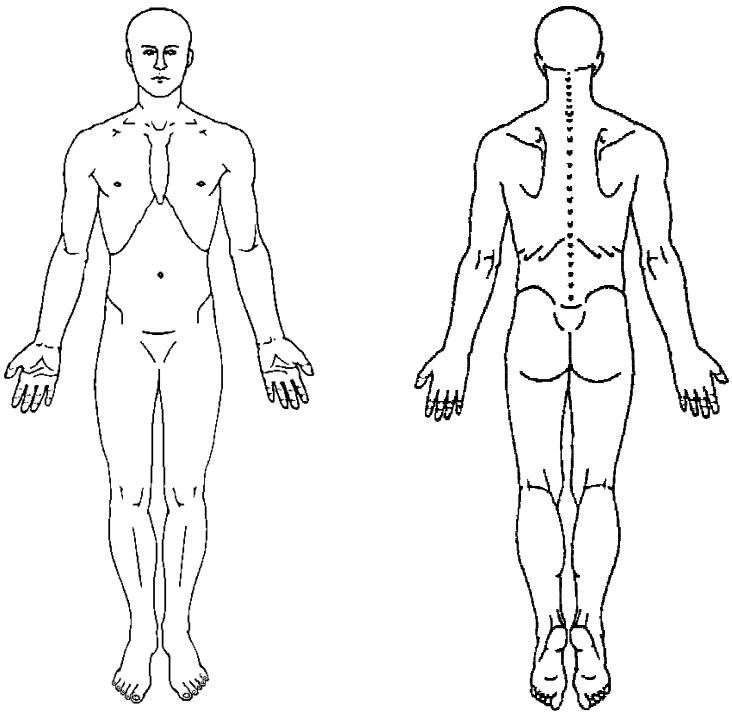
Please describe your health problem(s) or reason(s) for coming to the clinic:

_____

Have you had any previous treatment for this problem? ☐ No ☐ Yes ➜ Please describe and give dates:

_____

If you are suffering from pain, please draw the location(s) on the body diagrams below:



Please rate the extent of your pain or ache by circling a number below:

No pain

0
1
2
3
4
5
6
7
8
9
10

Unbearable Pain

Please describe the pain: _____

When and how did this problem start? _____

Does anything make it worse (lifting, coughing, etc)? _____

Does anything make it better (heat, rest, aspirin, etc)? _____

When is the problem most apparent? (Check all that apply) ☐ Morning ☐ Day ☐ Night

Does it affect work/school? ☐ No ☐ Occasionally ☐ Frequently ☐ Constantly

Does it affect your sleep? ☐ No ☐ Occasionally ☐ Frequently ☐ Constantly

This problem/condition is.... ☐ Getting worse ☐ Staying the same ☐ Improving

Have you had any other symptoms? ☐ No ☐ Yes ➜ Please describe: _____

_____