SPINE & JOINT
CENTRAL OHIO

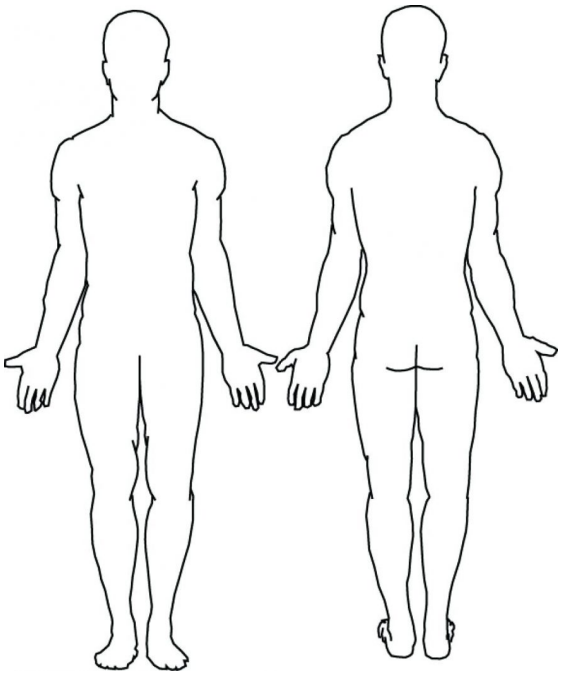
NEW COMPLAINT

Name: Date:

Condition / Problem	Severity											Frequency (% of week)										
Description	Minimal										Severe	Occasional										Constant
a.	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
b.	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
c.	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100

(Please mark the figures where you experience pain.)

Pain Chart



Symptoms are **worse** in the (check what applies)

- ☐ Morning
- ☐ Afternoon
- ☐ Night
- ☐ Increase during the day
- ☐ Same all day
- ☐ Decrease during the day

Symptom (a.) is: ☐ Sharp ☐ Dull ☐ Burning ☐ Aching ☐ Throbbing ☐ Tingling ☐ Numbness ☐ Pins & Needles

Symptom (b.) is: ☐ Sharp ☐ Dull ☐ Burning ☐ Aching ☐ Throbbing ☐ Tingling ☐ Numbness ☐ Pins & Needles

When did you symptoms begin (onset date)?

How did you symptoms begin?

Have you experienced these before?

Do your symptoms radiate?

Has your condition: ☐ Same ☐ Getting Worse ☐ Better

Check the things that make your problems **worse**:

- ☐ Bending
- ☐ Lying
- ☐ Twisting
- ☐ Walking
- ☐ Standing
- ☐ Lifting
- ☐ Sitting
- ☐ Movement
- ☐ Sleeping

Is there anything you can do to relieve the problems? ☐ No ☐ Yes (Describe):

If No, what have you tried that has not helped?

Is this condition interfering with ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Signature Date