



CHIEF COMPLAINTS OR SYMPTOMS

Name: _____ Date: _____

Neck Pain none left shoulder left arm left forearm left hand
check off the areas that the pain runs into from the neck right shoulder right arm right forearm right hand

headache
 Migraine Headache
 upper back pain

Ringling in Ears Yes No Left Right Both Ears
Blurry vision Yes No Left Right Both Eyes
Wrist Pain Yes No Left Right Both Wrists
Jaw Pain Yes No Left Right Both Side

Dizziness nervousness fatigue anxiety depression excessive irritability
 fear of driving a car a loss of concentration jaw clenching grinding of teeth at night
 nightmares difficulty with sleeping at night

Low Back Pain none buttocks left buttock left thigh left knee
select the areas of radiation, if any... left foot right buttock right thigh right knee right foot

Hip Pain Left Right Bilateral
Knee Pain Left Right Bilateral
Foot Pain Left Right Bilateral

Numbness/Tingling
 Left Hand Left Upper Arm Right Hand Right Upper Arm
 Left Foot Left Leg Right Foot Right Leg

Additional Symptoms/Complaints: _____

Have you lost any time from work due to your injuries? Yes No
If yes please give dates _____

Type of employment _____

Have you had previous injuries or accidents? Yes No

Description of previous accident _____

Description of previous injuries _____

Is there any residual pain from the previous injury? Yes No

How much better did you feel prior to your current condition?(Example 100%, 80% etc.) _____

Signature: _____ Date: _____