Patient Complaints

Date___/___/___ Name _____Signature_____

Is this visit a ___ Treatment Plan Appt. ___ Call In Appt. ___ Walk in **PI** Date of Injury_____

Any Changes in your health status since your last visit? (Meds, Surgery, diagnosis, injury, etc) ___YES ___NO
If YES, explain _____

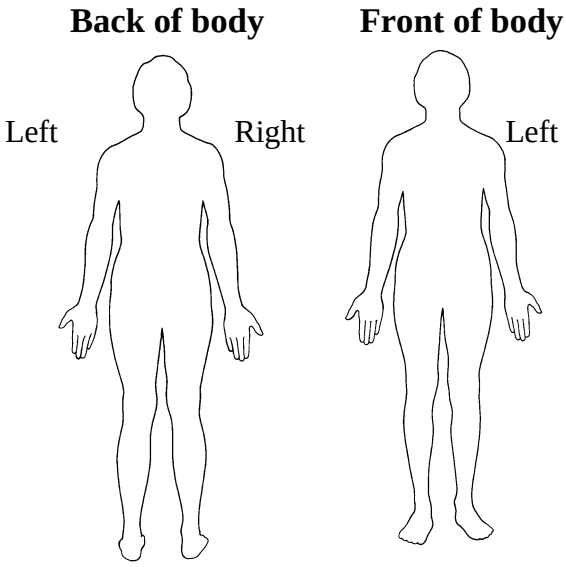
When did **TODAY'S** complaint begin? □ Today ___days ___weeks ___months ___continuing care plan

What happened to begin or worsen your complaint? _____

Is this a □ new condition **or my existing condition has** □ improved □ not changed □ worsened □ up & down

Were you treated by another healthcare provider for this complaint? □ yes □ no _____

Draw/mark your pain on the diagram below- include how the pain radiates to all areas



Please check the type of pain you feel
□Aching □ Burning □ Stabbing □Shooting □Nagging □Throbbing
□ Sharp □Dull □ Spasms □Numbness □Tingling □ Stiffness

My pain **right now** is No pain 1 2 3 4 5 6 7 8 9 10 worst pain
My pain at its **worst** is No pain 1 2 3 4 5 6 7 8 9 10 worst pain
My pain at its **least** is No pain 1 2 3 4 5 6 7 8 9 10 worst pain

How often do you experience your symptoms:
□ Constantly □ Frequently □ Occasionally □ Intermittently
75- 100% 50-75% 25-50% 1-25%

What activities make your condition worse:
□ bending □ stretching□ sleeping □walking □standing □sitting
□ lifting □ housework □ driving □ other _____

What activities help relieve your condition:
□ Ice □ heat □ chiropractic care □ massage □ pain meds □ positional changes □ rest □ other _____

How does this complaint interfere with your usual daily activities?
□ Not at all □ A little □ Moderately □ Quite a bit □ Extremely

In what areas of daily activities is it interfering?
□ sleeping □ bending □ stretching □walking □standing □sitting □ lifting □ housework □ driving
□ Other _____ □ limited range of motion in _____

COMMENTS:_____
_____

Opie Chiropractic Office
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Douglas D. Opie D.C. Chiropractic Physician

Dr. Initials: _____

Objective, Assessment, & Plan

Patient Name: Attending doctor:

Date of Service:

Chief Complaint

Objective

P.A.R.T

Cervical:

Thoracic:

Lumbar:

Pelvic:

Assessment

Plan
