



Integro Chiropractic
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Detailed Complaint Information

Patient Name: _____ Date: _____

Complaint #1: Where is your pain? _____

When did you first notice this condition? _____

Did it begin [] Immediately or [] Gradually? (please describe briefly) _____

Do your symptoms spread? [] No [] Yes Where? _____

How often do you experience these symptoms?

[] Constant [] Frequent (75% of day) [] Often (50%)

[] Seldom (25%) [] Rarely (less than 25%)

Is this condition progressively [] Worsening [] Improving [] Unchanged

What is the intensity of your symptoms? [] Severe [] Moderate [] Mild

Rate your symptoms on a scale of 1-10 considering 1 is minimal and 10 is severe _____

Is your pain [] Deep or [] Superficial

Please indicate the character of your pain: [] Dull [] Sharp [] Burning [] Aching

[] Knife-like [] Throbbing

Are you experiencing any of the following associated symptoms? [] Pins and Needles

[] Tingling [] Numbness [] Twitching of muscles If yes, please describe: _____

Please indicate what activities provoke (P) or aggravate (A) your condition:

[] Sitting _____ min [] Pushing [] Bowel Movements [] Bright Lights

[] Standing [] Pulling [] Mental Activities [] _____

[] Walking [] Lifting _____ lbs. [] Coughing/sneezing [] _____

[] Lying [] Gripping [] Hot or Cold [] _____

Please indicate what helps you to relieve the pain:

[] Lying [] Walking [] Rest [] Medications _____

[] Sitting [] Standing [] Heat or Cold [] _____

Please list what doctors you have seen for this condition (Including diagnoses, treatment received, and any changes in your condition): _____

Please include any other relevant history in regards to this complaint: _____