Justin Linker D.C.

Complaint / Incident Form

Planet Chiropractic
"Discover the World of Health"

Patient Name:______________________________ Date:__________

HISTORY OF COMPLAINT OR INCIDENT: Please fill in accurate information in the spaces provided below.

1.) **Primary Complaint:** What is your complaint(s)?______________________________

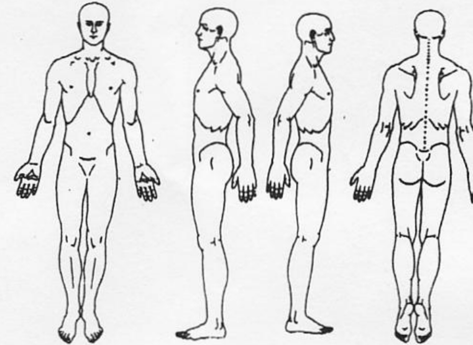
____

2.) **Mode of Onset** : What started this pain? ______________________________

3.) **Date of Onset**: When did this start? ______________________________

4.) **Location** : Where on your body is the problem? ______________________________

____



Please mark off the areas of your complaint on the diagram →.
Please use the following symbols on the pain diagram to accurately describe your condition.

P - Where you experience Pain
N - Where you experience Numbness
T - Where you experience Tingling
B - Where you experience Burning
C - Where you experience Cramping

5.) **Quantity / Severity** : How much does it hurt?
☐ Mild ~ Annoyance / No Impairment ☐ Moderate ~ Marked Impairment ☐ Severe ~ Incapacitated

On a scale of 1 to 10 (1 being no pain, 10 worst pain) how would you rate it? V.A.S. __________

6.) **Quality / Character** : What does it feel like? ☐ Dull Ache ☐ Burning ☐ Sharp/Stabbing ☐ Throbbing
☐ Other ______________________________

7.) **Duration/Frequency** : How long does it last? ☐ Intermittent 0-25% ☐ Occasional: 26-50%
☐ Frequent: 51-75% ☐ Constant 76-100% ☐ Other______________________________

8.) **Relation to other body systems** : Do you experience problems with any of the following?
☐ Bowel/Bladder ☐ Numbness/Tingling ☐ Muscle Weakness ☐ Referring/Radiating
☐ Other______________________________

9.) **Relieving Factors** : What makes it feel better? ☐ Rest ☐ Exercise ☐ Sitting ☐ Standing ☐ Lying ☐ Heat ☐ Ice
☐ Medication ______________________________ ☐ Other______________________________

10.) **Aggravating Factors** : What makes it feel worse? ☐ Coughing ☐ Sneezing ☐ Bowel Movement ☐ Lifting
☐ Bending ☐ Pushing ☐ Pulling ☐ Walking ☐ Running ☐ Sitting ☐ Standing
☐ Lying ☐ Changing body Positions ☐ Other______________________________

11.) **Additional Info. RE: Complaint/Incident** ☐ Patient Declines Additional Comment
☐ Other______________________________

<u>Information below must be filled in by the Doctor</u>

1.) **Diagnosis - ICD Codes** ______________________________

2.) **Plan for Treatment/ Recommendations** ______________________________

____

____

Doctor Signature ______________________________ Date__________