

Primary Complaint(s):

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Please describe your condition when it is at its worse:

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**PLEASE NOTE THE APPROPRIATE RESPONSE**

Overall frequency of complaint: (circle one please)

Constantly – 100 % of the time    Frequent – 75%    Intermittent – 50%    Occasional – 25%

Overall Intensity of complaint: (check one please)

- Minimal (an annoyance but has no effect on activity)
- Slight (Tolerable with some impairment to activity)
- Moderate (Tolerable with marked impairment of activity)
- Severe (Intolerable and cannot perform any activity)

Is your problem affecting any other areas of your body? If yes explain:

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Does it interfere with your normal daily activities (work, family, recreation)?

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What aggravates the problem?

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What relieves the problem; what have you tried for relief?

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If this went on without being taken care of, how do you think it would affect you?

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Any questions or concerns? \_\_\_\_\_

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