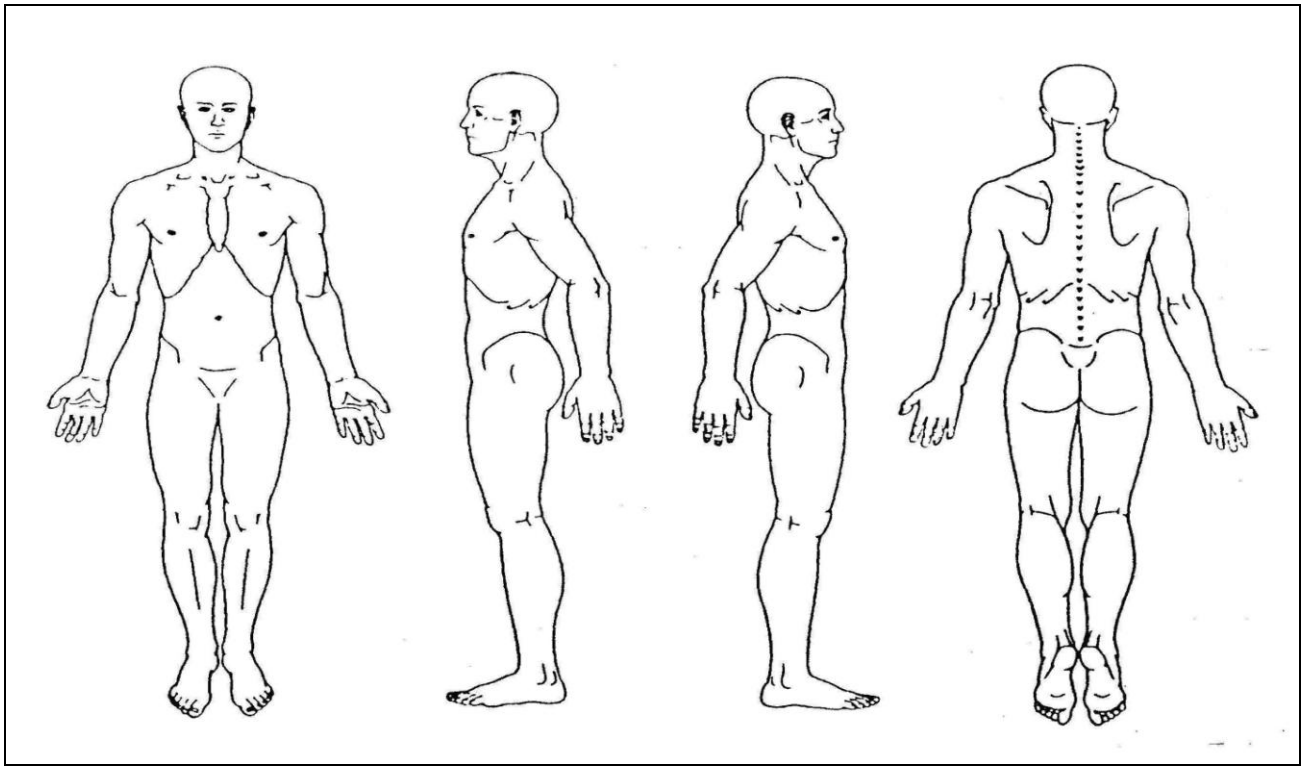
New Complaint/Episode Report

Patient: _____ Date: _____/_____/_____

Please accurately color the EXACT area of each pain:
Place a number (0[None] – 10[unbearable]) next to each area to indicate the level of the pain:



How did it happen? _____
_____

Quality and character: Sharp, dull, burning, shooting, stabbing, ache, numb, tingling, pins and needles, sore, stiff… Other: _____
When did it start (this time, if you've had it before)? _____
Have you had it before? How many times? _____
How bad is it? Pain Level 0-10: _____
How much of the day does it hurt? _____%
PSFS: (Please complete the PSFS Form on the other side)
What makes it feel better? _____

Who else have you seen for this? (Doctors, Physical Therapist, Chiropractor, etc.):
_____
Medications you've taken, including OTC:
_____

Have you had any changes in your recent health history: _____

Signed: _____ Date: _____/_____/_____

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