

Today's Date:

**List your Pains/Complaints from Most Severe (1) to Least (4)**

	1.	2.	3.	4.
Today, you have the following physical complaints:	_____	_____	_____	_____
Is this Complaint: Sharp, Dull, Achy, Throbbing, Numb, Shooting or Other (explain)?	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Numb <input type="checkbox"/> Electric/Shooting	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Numb <input type="checkbox"/> Electric/Shooting	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Numb <input type="checkbox"/> Electric/Shooting	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Numb <input type="checkbox"/> Electric/Shooting
How often do you feel this Complaint? Constant, Daily, Off & On, Weekly?	<input type="checkbox"/> Constant <input type="checkbox"/> Daily <input type="checkbox"/> Off & On <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____	<input type="checkbox"/> Constant <input type="checkbox"/> Daily <input type="checkbox"/> Off & On <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____	<input type="checkbox"/> Constant <input type="checkbox"/> Daily <input type="checkbox"/> Off & On <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____	<input type="checkbox"/> Constant <input type="checkbox"/> Daily <input type="checkbox"/> Off & On <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____
How long have you had this?	_____	_____	_____	_____
Is it getting better, worse or staying the same?	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same
What makes it better?	_____	_____	_____	_____
What makes it worse?	_____	_____	_____	_____
On a scale of 1-10 Rate your discomfort:	<p align="center"><b>Circle one</b></p> <p align="center"><u>10 9 8 7 6 5 4 3 2 1 0</u></p> <p align="center">10 = Excruciating 0 = No Discomfort</p>	<p align="center"><b>Circle one</b></p> <p align="center"><u>10 9 8 7 6 5 4 3 2 1 0</u></p> <p align="center">10 = Excruciating 0 = No Discomfort</p>	<p align="center"><b>Circle one</b></p> <p align="center"><u>10 9 8 7 6 5 4 3 2 1 0</u></p> <p align="center">10 = Excruciating 0 = No Discomfort</p>	<p align="center"><b>Circle one</b></p> <p align="center"><u>10 9 8 7 6 5 4 3 2 1 0</u></p> <p align="center">10 = Excruciating 0 = No Discomfort</p>
How have you taken care of this in the past? How has it worked for you?	_____	_____	_____	_____
This issue is effecting my:	<input type="checkbox"/> Job <input type="checkbox"/> Childcare <input type="checkbox"/> Marriage <input type="checkbox"/> Sex <input type="checkbox"/> Sports <input type="checkbox"/> Finances <input type="checkbox"/> Playing with kids <input type="checkbox"/> Bowels <input type="checkbox"/> Urine	<input type="checkbox"/> Job <input type="checkbox"/> Childcare <input type="checkbox"/> Marriage <input type="checkbox"/> Sex <input type="checkbox"/> Sports <input type="checkbox"/> Finances <input type="checkbox"/> Playing with kids <input type="checkbox"/> Bowels <input type="checkbox"/> Urine	<input type="checkbox"/> Job <input type="checkbox"/> Childcare <input type="checkbox"/> Marriage <input type="checkbox"/> Sex <input type="checkbox"/> Sports <input type="checkbox"/> Finances <input type="checkbox"/> Playing with kids <input type="checkbox"/> Bowels <input type="checkbox"/> Urine	<input type="checkbox"/> Job <input type="checkbox"/> Childcare <input type="checkbox"/> Marriage <input type="checkbox"/> Sex <input type="checkbox"/> Sports <input type="checkbox"/> Finances <input type="checkbox"/> Playing with kids <input type="checkbox"/> Bowels <input type="checkbox"/> Urine
Helping this issue would increase my Quality of Life by:	<input type="checkbox"/> 10-20% <input type="checkbox"/> 30-40% <input type="checkbox"/> 50-60% <input type="checkbox"/> 70-80% <input type="checkbox"/> 90-100%	<input type="checkbox"/> 10-20% <input type="checkbox"/> 30-40% <input type="checkbox"/> 50-60% <input type="checkbox"/> 70-80% <input type="checkbox"/> 90-100%	<input type="checkbox"/> 10-20% <input type="checkbox"/> 30-40% <input type="checkbox"/> 50-60% <input type="checkbox"/> 70-80% <input type="checkbox"/> 90-100%	<input type="checkbox"/> 10-20% <input type="checkbox"/> 30-40% <input type="checkbox"/> 50-60% <input type="checkbox"/> 70-80% <input type="checkbox"/> 90-100%