NEW COMPLAINT QUESTIONNAIRE

1. Where is your problem?
   - Shoulder
   - Hip
   - Neck
   - Arm
   - Thigh
   - Back
   - Elbow
   - Knee
   - Forearm
   - Leg
   - Wrist
   - Ankle
   - Hand
   - Foot

2. Which side is bothering you?
   - Right
   - Left
   - Both sides

3. When did it start? _____ / _____ / _______

4. Did the problem start: 
   - Suddenly
   - Gradually

5. Is your problem getting: 
   - Worse
   - Better
   - Staying the same

6. Was this a result of an injury? 
   - Yes
   - No
   If yes, please describe below how it happened:
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

7. How bad is your pain?
   (No pain) 1 2 3 4 5 6 7 8 9 10 (Extreme Pain)

8. How would you describe your pain (check only one)?
   - Constant
   - Comes and goes
9. How would you describe your pain (check all that apply)?
   - Dull
   - Sharp
   - Burning
   - Throbbing
   - Aching
   - Other (explain) -

10. What makes your problem better?

11. What makes your problem worse?

12. Which of the following treatments have you had for your problem?

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Did you get relief?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Medication</td>
<td>Yes</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>Yes</td>
</tr>
<tr>
<td>Injections</td>
<td>Yes</td>
</tr>
<tr>
<td>Surgery</td>
<td>Yes</td>
</tr>
<tr>
<td>Other</td>
<td>Yes</td>
</tr>
</tbody>
</table>

   Type: ____________________________
   How long did you attend? ______
   Describe: ______________________

13. Is there a legal case involved with this injury?  □ Yes  □ No

14. Please list below any changes in your medical history since your last visit (new medical problem, surgery, medicines, allergies, etc.).  □ No change in medical history

   __________________________________________
   __________________________________________
   __________________________________________