CHIEF Complaints or Symptoms: **Name:** **Date:**

☐ **Neck pain** Select the areas of pain radiation, if any: ☐ Headache ☐ Migraine Headache ☐ Upper back pain	☐ None ☐ Left shoulder ☐ Left arm ☐ Left forearm ☐ Left hand ☐ Right shoulder ☐ Right arm ☐ Right forearm ☐ Right hand

Ringing in Ears	☐ Yes ☐ No	☐ Left	☐ Right	☐ Both Ears	
Blurry Vision	☐ Yes ☐ No	☐ Left	☐ Right	☐ Both Eyes	
Wrist Pain	☐ Yes ☐ No	☐ Left	☐ Right	☐ Both Wrists	
Jaw Pain	☐ Yes ☐ No	☐ Left	☐ Right	☐ Both Sides	

☐ Dizziness ☐ Nervousness ☐ Fatigue ☐ Anxiety ☐ Depression ☐ Excessive irritability
☐ Fear of driving in a car ☐ A loss of concentration ☐ Jaw clenching ☐ Grinding of teeth at night
☐ Nightmares ☐ Difficulty with sleeping at night

☐ **Low Back Pain** Select the areas of radiation, if any…	☐ None ☐ Buttocks ☐ Left buttock ☐ Left thigh ☐ Left knee ☐ Left foot ☐ Right buttock ☐ Right thigh ☐ Right knee ☐ Right foot

Hip Pain	☐ Left	☐ Right	☐ Bilateral
Knee Pain	☐ Left	☐ Right	☐ Bilateral
Foot Pain	☐ Left	☐ Right	☐ Bilateral

Numbness:

☐ Left Hand	☐ Left Upper Arm	☐ Right Hand	☐ Right Upper Arm
☐ Left Foot	☐ Left Leg	☐ Right Foot	☐ Right Leg

Additional Symptoms/ Complaints:

_____

_____

_____

Have You lost any time from work due to your injuries? ☐Yes ☐No

If yes please give dates:

_____

Type of employment:

_____

Have you had previous injuries or accidents? ☐Yes ☐ No

Date of previous Accident:

_____

Date of previous Injuries:

_____

Is there any residual pain from the previous injury? ☐Yes ☐No

How much better did you feel prior to your current condition? (Example 100%, 80% etc.) _____