New Complaint Form

ABLE BODY HEALTH CLINIC
www.ablebody.ca

Name: _____ Date: _____

1) Please tell us the reason for your appointment: _____

2) When did this complaint begin? _____

3) Have you had a similar complaint before? ❑ NO ❑ YES If Yes, How long ago? _____

4) Have you received any tests or treatment for this complaint? ❑ NO ❑ YES If Yes, when? _____

5) Any recent accidents, injuries or surgeries? ❑ NO ❑ YES If Yes, Date: _____

6) Any recent changes to your medications? ❑ NO ❑ YES If Yes, Detail: _____

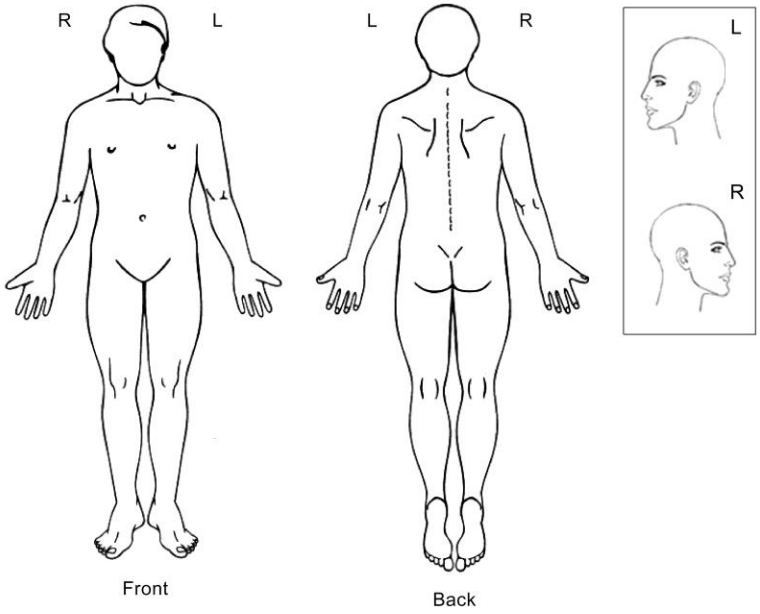
7) Please draw a face on the diagram below.

8) Please indicate how severe your pain or discomfort is today by circling the most appropriate number below:

No Pain - 0 1 2 3 4 5 6 7 8 9 10 *- Worst Pain Possible*

9) Please use the symbols provided below to mark the pain or sensations you are experiencing.

Numbness	≡≡≡≡	Pins/Needles	~~~~	Burning	oooo
Sharp	xxxx	Dull/Achy	ΔΔΔΔ	Stiff/Tight	2222



Patient Signature: _____

Doctor's Notes: