Name:______________________________ Date:____________

Patient Chief Complaint Form

What is it that you would like us to help you with:______________

____

What is your body doing and why?__________________________

____

Pain level on a scale of 1-10, 10 being the worst?_________________

How is it affecting your life?________________________________

____

____

What have you done to alleviate this problem?______________________

____

Would you like us to fix this problem without drugs or surgery?__________