GREENVILLE SPINE INSTITUTE
EXPERT CHIROPRACTIC CARE

Additional Complaint Form

If you experienced a sudden change in your physical condition or have another complaint you didn't mention originally, please provide details below.

Name: (please print) _____

Date of New Injury or Accident: _____ Time: _____

Cause? ❑ Lifting ❑ Fall ❑ Accident at work ❑ Automobile Accident ❑ Other

Please describe the new injury (explain the cause of the injury and your discomfort):

_____

_____

_____

When did it start? _____ Have you had it in the past: ❑ Y ❑ N When: _____

The pain/issue is: ❑ constant ❑ it comes and goes

On a scale from 1-10 with 10 being the worst circle the level of pain/discomfort: 1 2 3 4 5 6 7 8 9 10

Please circle the ones that best describe the pain/health concern:

❑ Sharp ❑ Stabbing ❑ Burning ❑ Dull ❑ Tingling ❑ Numbness ❑ Weakness ❑ Restriction

Other _____

Does your pain travel from the point of pain? ❑ Y ❑ N If yes, where: _____

What makes it better? Chiropractic Ice Heat Massage Medication Resting Sitting Standing Walking Lying Down

Other _____

What makes it worse? Bowel Movements Breathing Coughing Driving Sitting Lying Down Sneezing Walking Working

Other _____

List any out-of-ordinary pains, discomforts or other symptoms you have experienced as a result of this injury:

_____

_____

Have you missed any school/work due to this complaint? ❑ Y ❑ N

Is this the result of an automobile accident: ❑ Y ❑ N Work related injury: ❑ Y ❑ N

If yes, to either question above, please explain: _____

Have you received any other treatment for this condition: ❑ Y ❑ N

If yes, indicate treatment Chiropractic Physician Physical Therapy Surgery Other _____

Doctor's Name who provided Treatment: _____

Other comments: _____

Signed: _____ Date: _____