Primary Complaint Form

Diane Swift, LMP
Hand to Health Massage Therapy
509-660-0585

Patient Name____**Date**____________

Chief Complaint: (circle all that apply)

a. Neck Pain
b. Arm Pain R/L
c. Mid-back Pain
d. Low-back Pain
e. Leg Pain R/L
f. Headaches
g. Other______________________

Severity:

a. Mild – Annoyance, no impairment
b. Slight – Some mild impairment
c. Moderate – Marked impairment
d. Severe - Incapacitated/bed ridden

Duration:

a. Intermittent
b. Occasional
c. Frequent
d. Constant
e. Other____________________________

Quality:

a. Dull ache
b. Throbbing
c. Burning
d. Sharp/Stabbing/Shooting
e. Pins and Needles
f. Numbness/Tingling

Do over-the-counter pain relievers help?________

Date of Onset:__________________________

Mode of Onset:

a. Overexertion/Strenuous Position
b. Auto Accident
c. Fall/Trip/Slip
d. Poor Posture/Work Environment
e. Sports Injury
f. Other_____________________________

Pain level when aggravated:

0 1 2 3 4 5 6 7 8 9 10

No pain ... Severe pain

Pain level today:

0 1 2 3 4 5 6 7 8 9 10

No pain ... Severe pain

Aggravating Factors:

a. Cough/Sneeze/Bowel Movement
b. Lifting/Bending/Push/Pull
c. Driving/Sitting
d. Walking/Standing
e. Sleeping/Lying Down
f. Exercise – Mild/Strenuous
g. Other_____________________________

Therapist Notes:____

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TX Frequency:____________________________Duration____________________________________

(___)Initial Report (___)Interim Report (___)Final Report