COMPLAINT/INCIDENT REPORT

Patient's Name _____ Date _____

Please list your primary problem/pain area(s) and circle your pain level (10 is severe):

_____ 0 1 2 3 4 5 6 7 8 9 10

Describe your pain (circle any): Ache Burning Sharp Stabbing Numb Tingling

When did it start? _____

What were you doing when you first noticed it? _____

Does anything make it better? _____

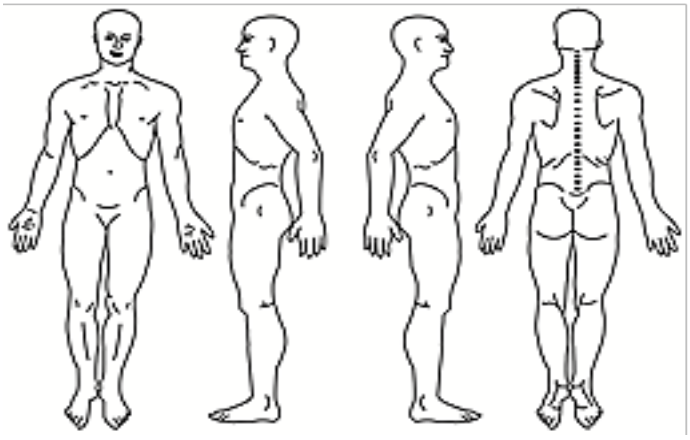
Does anything make it worse? _____

Other problem/pain area(s):

_____ 0 1 2 3 4 5 6 7 8 9 10

_____ 0 1 2 3 4 5 6 7 8 9 10

Please mark on the diagram below where you are experiencing pain or other symptoms**:**



Patient's Signature: _____

2213 West Interstate 40 • Amarillo, Texas 79109 • Phone: 806.355.5800 • Fax: 806.355.1400