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**CURRENT MEDICAL COMPLAINTS**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Area of Injury

List each body part on separate papers: \_\_\_\_\_

Instructions: Circle appropriate answers or provide additional information as needed. Be very specific and detailed.

Describe pain level:

At rest: 0 1 2 3 4 5 6 7 8 9 10

With Activity 0 1 2 3 4 5 6 7 8 9 10  
Some Livable Needs Meds Incapacitated

Describe frequency: Constant Frequent Intermittent No pain  
Other:

Describe pain: Aching Dull Sharp Stabbing Shooting Throbbing  
Other:

Does pain move:  
(if yes where)

Aggravating factors: Walking Standing Running Kneeling Squatting Bending Stairs Sitting Lying  
(makes it worse) Lifting Carrying Pulling Pushing Gripping Grasping Writing Typing Driving  
Other:

Alleviating factors: Walking Standing Stretching Sitting Exercise Physical Therapy Medication Rest  
(makes it better) Ice Heat Lying down Sleeping  
Other:

Any other symptoms: Numbness Tingling Weakness Swelling Discoloration Depression Anxiety Insomnia  
Other: