PATIENT CASE HISTORY

Name: _____ Address: _____

City: _____ State/ Zip: _____ Phone: _____

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity		Frequency (% of week)	
	Minimal	Severe	Occasional	Constant
a._____	0 1 2 3 4 5 6 7 8 9 10		0 10 20 30 40 50 60 70 80 90 100	
b._____	0 1 2 3 4 5 6 7 8 9 10		0 10 20 30 40 50 60 70 80 90 100	
c._____	0 1 2 3 4 5 6 7 8 9 10		0 10 20 30 40 50 60 70 80 90 100	
d._____	0 1 2 3 4 5 6 7 8 9 10		0 10 20 30 40 50 60 70 80 90 100	

(Please mark the figures where you experience pain.)

2. Symptoms are <u>worse</u> in the (circle what applies)

   -morning   -Increase during the day

   -afternoon   -same all day

   -night   -decrease during the day
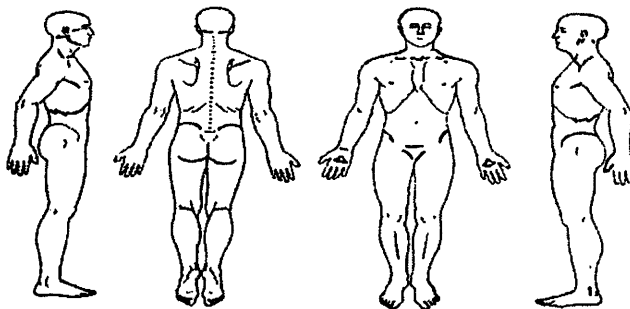
3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

5. When did your symptoms begin (onset date)? _____

6. How did your symptoms begin? _____

7. Have you experienced these before? _____

8. Do your symptoms radiate? _____

9. Has your condition? _____ Improved _____ Gotten Worse _____ Stayed the same since it began

10. Circle the things that make your problems worse:

      Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

11. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____

   If No, what have you tried that has not helped? _____

12. Have you been treated for this before? ____No ____Yes How long ago? _____

13. What treatment did you receive? _____

14. Results of previous treatment? ____Good ____Poor Comments _____

15. Were you referred to our office by anyone? _____

16. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation

17. List any other major injuries you have had, other than those mentioned above: _____

_____

18. Any other Musculoskeletal problems? ____No ____Yes ...Neurological problems? ____No ____ Yes

____Additional information on back side of sheet.

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date: _____