

CASE HISTORY

Name: _____

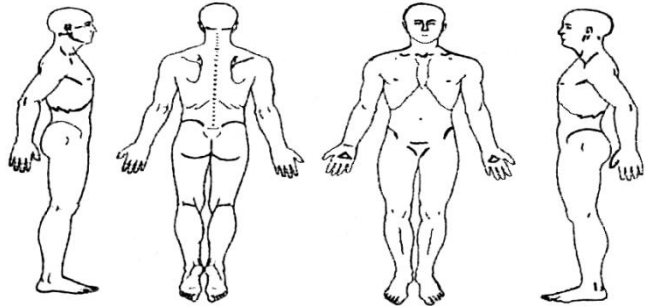
1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

| 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 |
| e. _____ | 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 worse 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

19. How do these following activities impact your condition?

- a. Walking: Increase / Decrease Symptoms: I can walk _____ min. before symptoms begin / increase
additional notes for walking: _____
- b. Sleeping: I have problems falling asleep / staying asleep / wake up stiff & sore in mornings
additional notes for sleep: _____
- c. Standing: Increase / Decrease Symptoms: I can stand unassisted _____ min. before symptoms begin / increase
additional notes for standing: _____
- d. Lifting: Increase / Decrease Symptoms: I can lift _____ lb. with ease / without symptoms
additional notes for lifting: _____
- e. Bending: Increase / Decrease Symptoms: I can bend easily / have to use assistance / sit to bend
additional notes for bending: _____
- f. Lying Flat: Increase / Decrease Symptoms: I can lay on Right Side / Back / Left Side Symptom Free
additional notes for lying: _____
- g. Sitting: Increase / Decrease Symptoms: I can sit _____ min. before symptoms begin
I go sitting to standing easily/ using my hands to walk up legs / use assistance / no pain / moderate pain/ severe pain
additional notes for sitting: _____
- h. Any other activity that you currently can't do or that aggravates your symptoms: _____

20. I am currently utilizing the following activities also to help:

Massage Nutritional Supplements Prescription Medication Over-the-Counter Medications Exercise Physical Therapy
additional notes: _____

21. Current Medications: _____

22. Current Medical Diagnoses: _____

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

Patient/Guardian Signature _____ Date: _____