

Confidential Patient Case History

Please fill out, check or circle your answers to the following questions:

What is your major complaint?

- Neck pain Mid back pain Low back pain Shoulder (L/R) Arm (L/R) Elbow (L/R) Knee (L/R)
 Ankle (L/R) Hips (L/R) Other: _____ Date of Onset: _____
Pain: Does not radiate Radiates from: _____ to _____ and from: _____ to _____

Is the pain associated with: Numbness Tingling Muscle Weakness Fever Other: _____

The pain is:

- Mild (1, 2, 3)
- Moderate (4, 5, 6)
- Severe (7, 8, 9)
- Very severe (10)

The pain is:

- Sharp Stabbing
- Dull/ache Discomforting
- Burning Throbbing
- Shooting Other: _____

The pain is:

- On & off
- Frequent
- Constant
- Occurs with movement

How long have you had this condition? Days Weeks Months Years

Have you had this or a similar condition in the past? _____

Do any of the following activities make the condition feel worse?

- Walking Sitting Driving Standing Bending Lifting

Is this condition: Improved Unchanged Getting worse

Is this condition interfering with your: Work Sleep Daily Routine Intimacy Other: _____

Have you lost any time at work/other activities as a result of this condition? Yes (_____ days) No

Other doctors/therapists who have treated you for this condition: _____

On the diagram below:

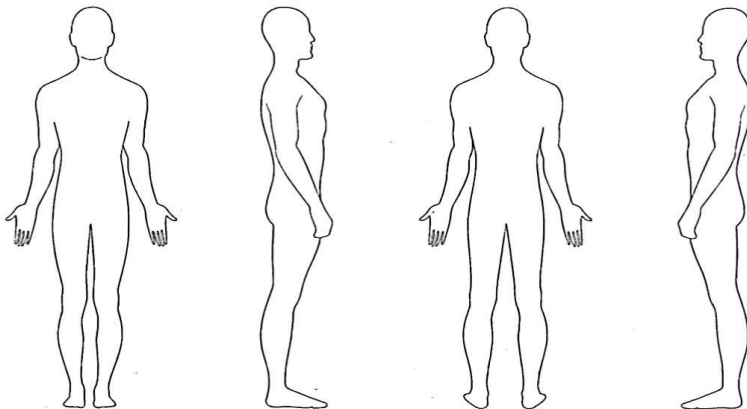
Put an "X" on the area(s) where you feel pain.

SHADE the areas that hurt the most.

"+++" for areas with tingling.

OOOO for areas with numbness.

What pain treatments or medications are you receiving now or have receive in the past? Rate each treatment on a scale of 1-10 in ters of their effectiveness in relieving your pain.



Treatment/medication: _____

Level of relief: _____

Receiving now? Yes No

Treatment/medication: _____

Level of relief: _____

Receiving now? Yes No

Treatment/medication: _____

Level of relief: _____

Receiving now? Yes No

Patient Name (Print/Signature): _____ Date: _____