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: ________________

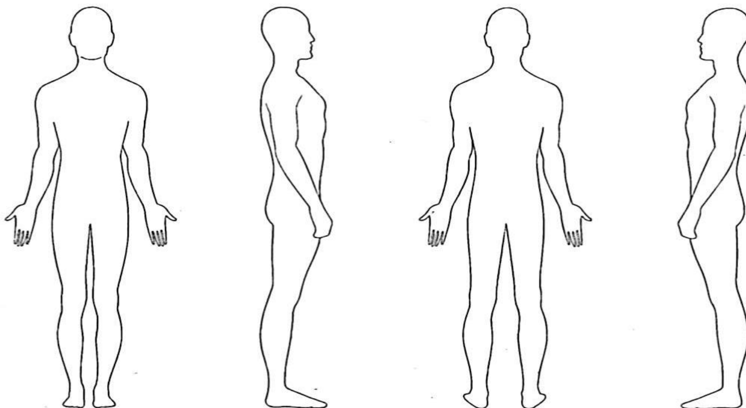
The pain is:	The pain is:		The pain is:
□ Mild (1, 2, 3)	□ Sharp	□ Stabbing	□ On & off
□ Moderate (4, 5, 6)	□ Dull/ache	□ Discomforting	□ Frequent
□ Severe (7, 8, 9)	□ Burning	□ Throbbing	□ Constant
□ Very severe (10)	□ Shooting	□ Other: ________	□ Occurs with movement

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 activies 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: __________________