

**CASE HISTORY**

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

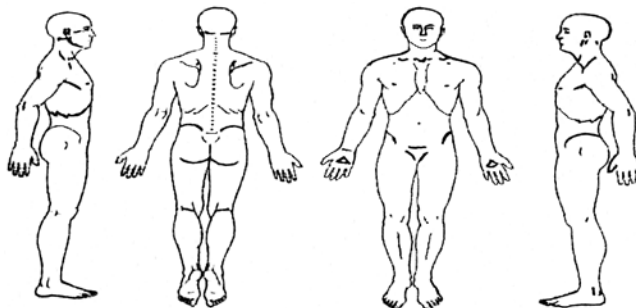
1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

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

\_\_\_\_\_  
 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: \_\_\_\_\_