

CONFIDENTIAL PATIENT CASE HISTORY

Mailing Address:

Nickname:

Marital Status:

Home Phone:

Employer:

Referred by:

Former Patient

Sex:

Spouse's Name:

Work Phone:

E-mail:

Fax:

Occupation:

What is your major complaint? _____

How long have you had this condition? _____

How did this condition begin? _____

Have you had this or similar conditions in the past? _____

Which positions make you feel better? _____

Which positions make you feel worse? _____

Describe the pain: " sharp, " dull, " aching, " burning, " throbbing, " other: _____

Does the pain radiate anywhere? (please describe) _____

Is this condition: " Improved, " Unchanged, " Getting Worse

Please draw a vertical line (|) on the line below to indicate your current level of pain.

No pain _____ Worst pain imaginable

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

Other doctors or therapists who have treated you for THIS condition: _____

List surgical operations and years: _____

Family Physician: _____

Medications, Dosage, & Frequency: _____

Have you been in an auto accident or had any personal injury? " Y " N Describe: _____

Signature

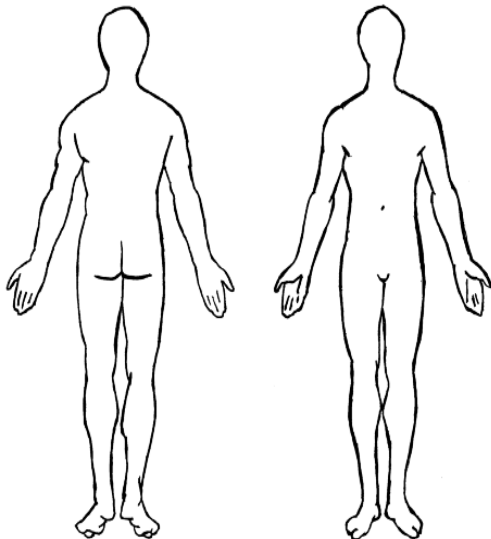
Date

REVIEW OF SYSTEMS: Please list any problems you have now or have had since your last visit.

- General Health _____
- Head & Ears _____
- Mouth, Nose, Throat _____
- Musculoskeletal System _____
- Heart & Vascular _____
- Respiratory _____
- Genito-Urinary _____
- Gastro-Intestinal _____
- Neurologic _____
- Psychiatric _____
- Immunologic _____
- Blood _____
- Skin _____
- Breast _____
- Endocrine _____
- Other _____

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE BELOW. Use the following symbols:

Aches ^^^^ Numbness 0000
 Pins/Needles Stabbing ////



Please circle the number that best describes the question being asked.

If more than one complaint please answer each question for each individual complaint and indicate which score is for which complaint.

Example: neck Headache Low Back

0 1 **2** 3 4 **5** 6 7 8 **9** 10

1. What is your pain **RIGHT NOW**?

0 1 2 3 4 5 6 7 8 9 10

2. What is your **TYPICAL** or **AVERAGE** pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain at it's **BEST**? (How close to 0 does it get?)

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain at its **WORST**? (How close to 10 does it get?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____ %

Patient Signature: _____

Date: _____