

# CASE HISTORY

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

Primary Reason For Today's Visit: \_\_\_\_\_

When Did Your Problem Begin: \_\_\_\_\_ How: \_\_\_\_\_

Please give a number to grade your pain: (1 = no pain, 10 = Unbearable Pain) \_\_\_\_\_

Check off all words that describe your pain:

Dull  Ache  Sharp  Shooting  Tingling  Throbbing  Burning

Stiff  Spasming  Weakness  Other: \_\_\_\_\_

How often throughout the day is your pain present:

Constant (100 – 81%)  Frequent (80 – 51%)  Occasional (50 – 26%)  Intermittent (25 – 0%)

Since your pain began, is it:  Getting Worse  Getting Better  Staying the Same

What Brings you Relief:

Nothing  Standing  Sitting  Lying Down  Moving Around  Heat  Cold

What makes you feel worse:

Nothing  Standing  Sitting  Lying Down  Moving Around  Heat  Cold

Have you sought any treatment for this condition?: \_\_\_\_\_

Have you had an episode like this in the past?: \_\_\_\_\_

Has This Affected Your:  Ability to Work  Home Life  Driving  Sports/Hobbies

Other: \_\_\_\_\_ If Out of Work, Please Give Dates: \_\_\_\_\_

When was your last Examination with your regular Physician: \_\_\_\_\_

**Are you on any**  Nerve Pills/Pain Killers/Muscle Relaxers  Blood Pressure  Insulin

**of the following**  Aspirin/Similar  Birth Control  Mood Stabilizers

**Medications:** Please List: \_\_\_\_\_

**Have you had any**  Appendix \_\_\_\_\_  Tonsils \_\_\_\_\_  Gall Bladder \_\_\_\_\_

**of the following**  Hernia \_\_\_\_\_  Cardiac \_\_\_\_\_  Back/Neck: \_\_\_\_\_

**Surgeries:**  Other: \_\_\_\_\_

Have you been treated for any injuries or health conditions in the past year?:  No  Yes

If yes, please give date and describe: \_\_\_\_\_

Have you ever:

Had a Motor Vehicle Accident (going over 10 mph)?:  No  Yes

Had a Major Injury, Sports Injury, Slip & Fall, Broken Bone?:  No  Yes

Had to be Hospitalized (Other than Surgeries listed above)?:  No  Yes

If yes to any of the above questions, please give date and describe: \_\_\_\_\_

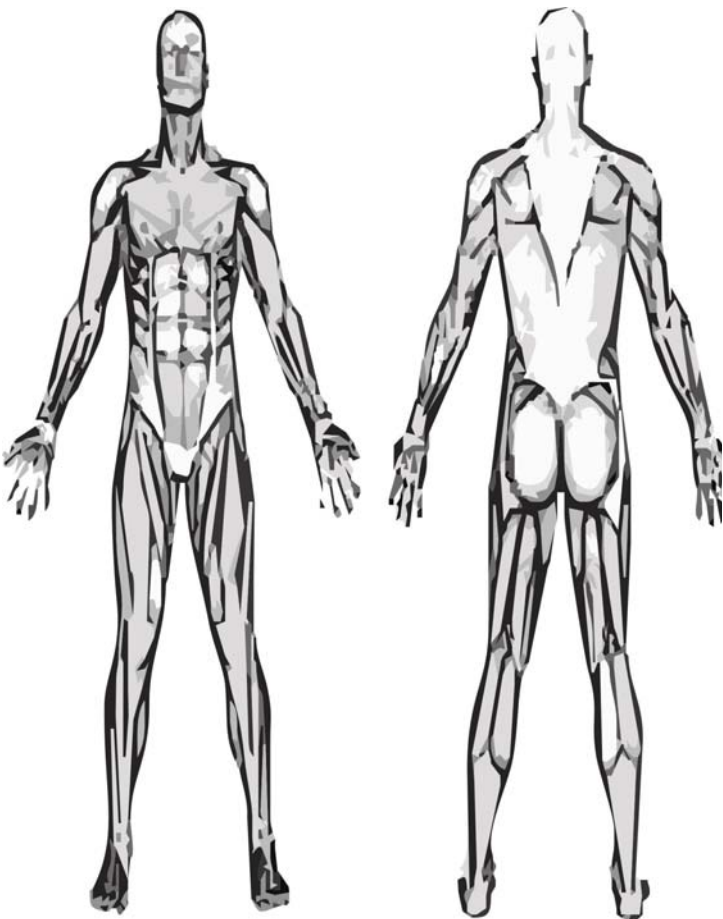
\_\_\_\_\_  
\_\_\_\_\_

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

*Please indicate if you have any of the following conditions now or in the past.*

<u>MUSCOLO-SKELETAL / NERVE:</u>			<u>DISEASES / SYNDROMES:</u>			<u>ORGAN / BODY SYSTEMS:</u>		
Y	N	Condition	Y	N	Condition	Y	N	Condition
◇	◇	Headaches	◇	◇	Cancer	◇	◇	Stroke
◇	◇	Scoliosis	◇	◇	Diabetes	◇	◇	Stress
◇	◇	Neck Pain	◇	◇	Arthritis	◇	◇	Chest Pain / Heart Attack
◇	◇	Mid-Back Pain	◇	◇	Osteoporosis/Osteopenia	◇	◇	Heart Disease
◇	◇	Lower Back Pain	◇	◇	Parkinson's Disease	◇	◇	Lung Disease
◇	◇	Shoulder/Arm Pain	◇	◇	Alzheimer's Disease	◇	◇	High / Low Blood Pressure
◇	◇	Hand Pain / Numbness	◇	◇	Multiple Sclerosis	◇	◇	Kidney Stones / Infection
◇	◇	Leg/Foot Pain	◇	◇	Epilepsy	◇	◇	Bladder Infection
◇	◇	Paralysis	◇	◇	Influenza / Pneumonia	◇	◇	Reproductive Problems
◇	◇	Dizziness	◇	◇	Tuberculosis	◇	◇	Yeast Infections
◇	◇	Numbness / Tingling	◇	◇	Mental / Mood Disorder	◇	◇	Poor/Excess Appetite
			◇	◇	Allergies (Seasonal or Food)	◇	◇	Excessive Thirst
						◇	◇	Frequent Nausea / Vomiting
						◇	◇	Heartburn
						◇	◇	Diarrhea / Constipation
						◇	◇	Vision Problems
						◇	◇	Dental Problems
						◇	◇	Frequent Ear Infections
						◇	◇	Loss of Hearing / Tinitis
						◇	◇	Loss of Smell
						◇	◇	Fatigue / Loss of Sleep
						◇	◇	Alcoholism / Substance abuse

**Please circle your area(s) of complaint:**



Other: \_\_\_\_\_

What is your average:

Alcohol: \_\_\_\_\_ drinks / week

Caffeine: \_\_\_\_\_ oz / day

Tobacco: \_\_\_\_\_ packs / day

Water: \_\_\_\_\_ oz / day

Exercise: \_\_\_\_\_ days / wk

Type of exercise: \_\_\_\_\_

Please Rate Your General Health:

(1 = poor, 10 = excellent): \_\_\_\_\_

Females:

Date of last Period?: \_\_\_\_\_

Are you Pregnant?: \_\_\_\_\_