

Confidential Patient Case History

Please fill out, check or circle the following questions:

What is your **major complaint**?

- Neck Pain Mid Back Pain Low Back Pain Shoulder (L / R)
 Arm/Elbow (L / R) Knee/Ankle (L / R)

Others: _____ 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: **no pain**, **mild** (1, 2, 3), **moderate** (4, 5, 6), **severe** (7, 8, 9), **very severe** (10)

The pain is: sharp, dull/ache, burning, shooting, stabbing, discomfort, throbbing,
 other: _____

The pain is: on & off, intermittent, 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

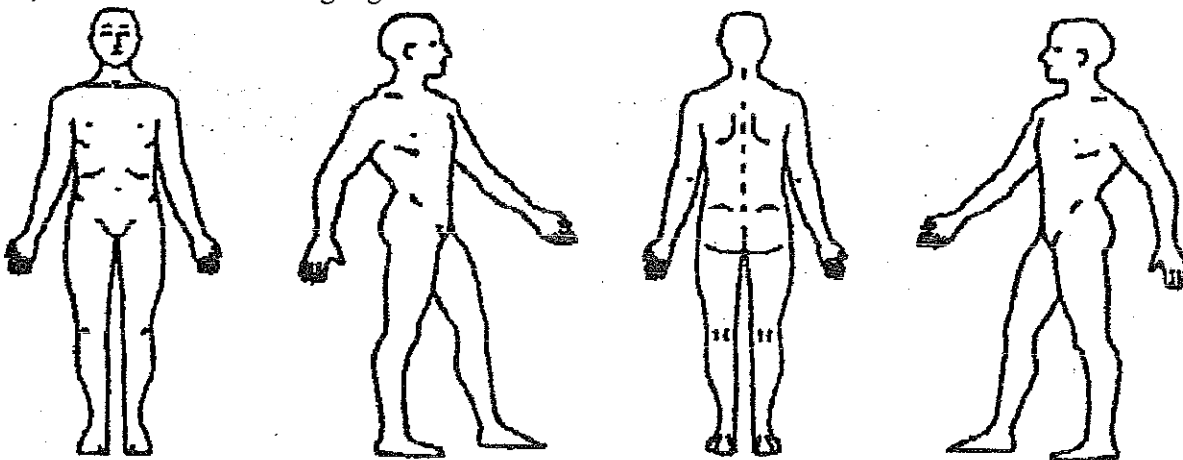
Is this condition: Improved Unchanged Getting Worse

Is this condition interfering with your: Work Sleep Daily Routine Sex 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 and **OOOO** for numbness.



What pain treatments or medications are you receiving now – or have received in the past?

Circle the number next to the treatment to signify the amount of pain relief that treatment is providing.

TREATMENT / MEDICATION	No Relief	Complete Relief	Check if Receiving Now
_____	0 1 2 3 4 5 6 7 8 9 10		<input type="checkbox"/>
_____	0 1 2 3 4 5 6 7 8 9 10		<input type="checkbox"/>
_____	0 1 2 3 4 5 6 7 8 9 10		<input type="checkbox"/>

Patient Print/Signature: _____

Date: _____