

## CASE HISTORY

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

List chief complaints (describe fully): \_\_\_\_\_

State the location of pain: \_\_\_\_\_

Describe what type of pain (sharp, dull, pinching, etc): \_\_\_\_\_

Does the pain radiate from primary location?  Yes  No If yes, where? \_\_\_\_\_

When did this start: \_\_\_\_\_ Did your symptoms begin:  Suddenly  Gradually

Did you have an accident?  Yes  No If yes, what kind?  Work  Auto  Other

Since your symptoms began, are they: Increasing/Getting worse Decreasing/Improving Staying the same

How often do you have pain? Constant Almost Constant Frequent Occasional On and Off  
Please circle (100%) (75% - 90%) (50% - 74%) (25% - 49%) (24% or less)

On a scale of 1 to 10, how bad is your pain currently?	0	1	2	3	4	5	6	7	8	9	10
	No Pain			Moderate				Unbearable			

Is your pain worse (please circle): At rest With activity In the AM In the PM

What makes your symptoms WORSE? \_\_\_\_\_

What makes your symptoms BETTER? \_\_\_\_\_

Have you used any ice or heat?  Ice  Heat How often? \_\_\_\_\_

Have you been treated by another doctor or physical therapist? If so, who have you seen: \_\_\_\_\_

Prior to your current condition, have you ever had any of the physical complaints similar to what you have now?  
 Yes  No  Don't know If yes, please describe: \_\_\_\_\_

Please rate your level of stress:	0	1	2	3	4	5	6	7	8	9	10
	None		Low			Moderate			High		

### PAST MEDICAL HISTORY

Please describe any accidents, any serious injury or history of serious illnesses not previously covered here.

Do you currently wear Orthotics?  Yes  No If yes, how long? \_\_\_\_\_

Are you taking any medications or supplements currently? \_\_\_\_\_