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

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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**

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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? _____

_____