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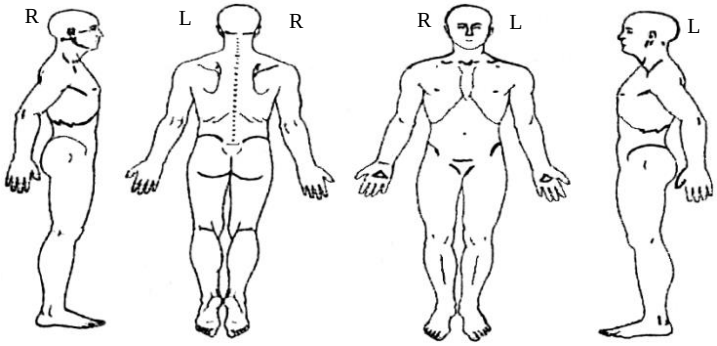
CASE HISTORY

Address change: Yes/No

Name: _____New Patient___ Re-exam__ Insurance Change: Yes/No

1. **Describe each Condition / Problem**	**Severity** (0=no pain, 10- very severe)	**Frequency** Intermittent	Occasional	Frequently	Constant
A)_____	0 1 2 3 4 5 6 7 8 9 10	0 -25%	26-50%	51-75%	76-100%
B)_____	0 1 2 3 4 5 6 7 8 9 10	0 -25%	26-50%	51-75%	76-100%
C)_____	0 1 2 3 4 5 6 7 8 9 10	0 -25%	26-50%	51-75%	76-100%
D)_____	0 1 2 3 4 5 6 7 8 9 10	0 -25%	26-50%	51-75%	76-100%

(Please mark the figures where you experience pain.)➔



2. Symptoms are worse in the (circle what applies)

-morning -Increase during the day
-afternoon -same all day
-night -decrease during the day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. Symptom (c.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
6. Symptom (d.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
7. Date of Onset: _____/_____ or the time frame of when you last experienced the condition:
   a. __ Acute (within last 3 months) __ Recurrent (multiple episodes <3 months) __ Chronic (continuous > 3 months)
8. How did your symptoms begin? _____
9. Have you experienced these before? When?_____
10. Do your symptoms radiate or cause weakness? _____
11. Any changes to bowel or urinary habits? _____
12. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
13. Circle the activities that make your problems worse:

    Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

14. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____

    If No, what have you tried that has not helped? _____
15. Have you been treated for this before? ___No ___Yes Who/How long ago? _____
16. What treatment did you receive? _____
17. Results of previous treatment? ___Good ___Poor Comments _____
18. Which activities of daily living does this pain interfere with?_____
19. List any other major injuries you have had, other than those mentioned above: _____

_____

20. Have you ever been diagnosed with Covid 19? _____ If yes, when? _____

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date: _____