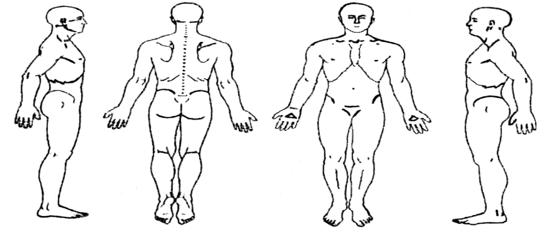
Patient Name ______________________________ Date ______________________

# Case History

Please circle the areas on the figures where you experience pain.



How much have your symptoms interfered with usual daily activities?

☐Not at all ☐A little bit ☐Moderately ☐Quite a bit ☐Extremely

Circle actions that make your symptoms worse:

Bending Lying Walking Standing Sitting Movement Twisting Lifting

| **Conditions/Problem** | **Severity & Frequency** | **Type** | **Onset** | **Relief & Treatment** |
|---|---|---|---|---|
| | **Severity**<br>0=No Pain to 10=Severe<br>0 1 2 3 4 5 6 7 8 9 10<br>**Frequency**<br>% of day 0=never to 100=constant<br>0 10 20 30 40 50 60 70 80 90 100 | ☐Dull ☐Ache<br>☐Burn ☐Throb<br>☐Numb ☐Tingling<br>☐Sharp<br>Does it radiate?<br>☐Y ☐N | Symptoms began on:<br>______/______/__________<br>Was it?☐Gradual ☐Sudden<br>Has it? ☐Gotten Worse<br>☐Stayed the same<br>How did symptoms begin?<br>____________________ | Anything to relieve symptoms? ☐Y ☐N<br>If yes:______________<br>**Prior Treatment?**<br>☐Y When?__________<br>☐N |
| | **Severity**<br>0=No Pain to 10=Severe<br>0 1 2 3 4 5 6 7 8 9 10<br>**Frequency**<br>% of day 0=never to 100=constant<br>0 10 20 30 40 50 60 70 80 90 100 | ☐Dull ☐Ache<br>☐Burn ☐Throb<br>☐Numb ☐Tingling<br>☐Sharp<br>Does it radiate?<br>☐Y ☐N | Symptoms began on:<br>______/______/__________<br>Was it?☐Gradual ☐Sudden<br>Has it? ☐Gotten Worse<br>☐Stayed the same<br>How did symptoms begin?<br>____________________ | Anything to relieve symptoms? ☐Y ☐N<br>If yes:______________<br>**Prior Treatment?**<br>☐Y When?__________<br>☐N |
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In general, would you say your overall health right now is…

☐Excellent ☐Very good ☐Good ☐Fair ☐Poor

Please list any health conditions, major illnesses, diseases not mentioned: ______________________________

Please list all past surgeries and/or operations: ______________________________

Please list any medications/supplements currently taking and their purpose: ______________________________

Do you smoke? ☐No ☐Yes, How much? ____________ Do you drink alcohol? ☐No ☐Yes, How much? ____________

Do you drink coffee/caffeinated beverages? ☐No ☐Yes, How much? ____________

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