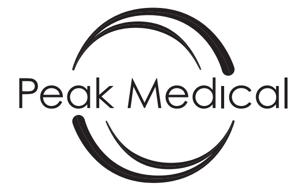
Confidential Patient Case History



Please fill out, check or circle your answers to 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:
☐ Mild (1,2,3)
☐ Moderate (4,5,6)
☐ Severe (7,8,9)
☐ Very severe (10)

The pain is:
☐ Sharp ☐ Stabbing
☐ Dull/ache ☐ Discomforting
☐ Burning ☐ Throbbing
☐ Shooting ☐ Other:____________

The pain is:
☐ 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

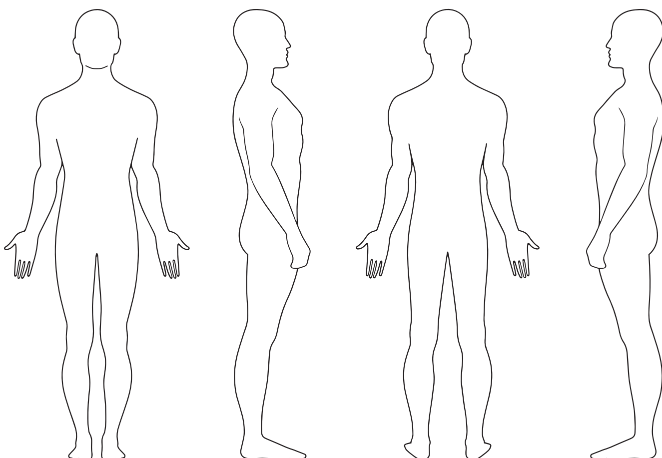
Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Intimacy ☐ Other: ______________

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 **0000** for numbness.



What pain treatments or medications are you receiving now or have received in the past? Rate each treatment on a scale of 1-10 in terms of their effectiveness in relieving your pain.

Treatment/medication: ______________________________

Level of relief: _________ Receiving now? ☐ Yes ☐ No

Treatment/medication: ______________________________

Level of relief: _________ Receiving now? ☐ Yes ☐ No

Treatment/medication: ______________________________

Level of relief: _________ Receiving now? ☐ Yes ☐ No

Patient Name (Print/Signature): ______________________________ Date: ____________