

CASE HISTORY

Patient Name: _____

Date: _____

Chief complaint (one per page): _____

My complaint began: _____

Did anything cause or contribute to onset? Yes No
 Was treatment sought? Yes No
 Have you ever had anything like this before? Yes No
 Has the condition worsened/improved since onset? Yes No
 I have tingling and/or numbness. Yes No

Currently my pain is (circle one):

- Minimal: An annoyance with no impairment.
- Slight: Tolerable, with some impairment.
- Moderate: Marked impairment.
- Marked: Total impairment.

My pain is (circle one):

- Intermittent: Less than 25% of waking hours.
- Occasional: Between 25 & 50% of waking hours.
- Frequent: Between 50 & 75% of waking hours.
- Constant: Between 75 & 100% of waking hours.

The onset of my pain was: Gradual Sudden

My pain radiates: Yes No

My pain is worse when I:

Cough or sneeze	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Walk	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sit	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bend (F.B.L.R.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stand from sitting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Push	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Turning in bed	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pull	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lay on my back	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Strain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lay on my stomach	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Look up	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lay on my right side	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Look down	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lay on my left side	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Turn my head	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stand	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Raise my arms	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Twist	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

My pain wakes me during the night: Yes No

Changes in weather affect my pain: Yes No

I have stiffness: Yes No

I have headaches: Yes No

If I do get headaches, they occur: Sometimes All of the time

My pain is alleviated by (list in order of best to least): _____

Other pain or symptoms (please describe any current complaint listed in health history needing further detail, which you are experiencing and not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition): _____

