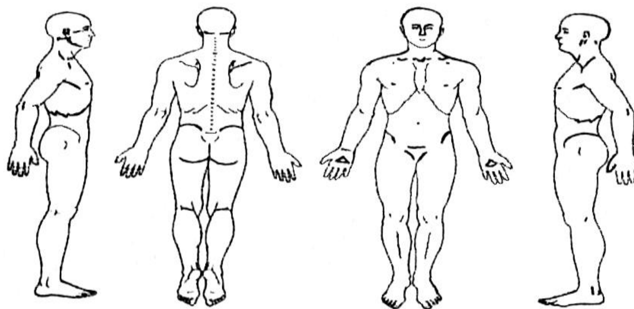
CASE HISTORY

Name: ________________________________

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity (Minimal … Severe)	Frequency (% of week) (Occasional … Constant)
a.________________	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b.________________	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c.________________	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d.________________	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

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

2. When did your symptoms begin (onset date)? ________________________________
3. How did your symptoms begin? ________________________________
4. Have you experienced these before? ________________________________
5. Do your symptoms radiate? ________________________________
6. Has your condition? Improved ___ Gotten Worse ___ Stayed the same since its onset ___
7. Circle the things that make your problems worse:

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

8. Is there anything you can do to relieve the problems? No ___ Yes ___ Describe: ________________

   If No, what have you tried that has not helped? ________________________________

10. Have you been treated for this before? No ___ Yes ___ How long ago? ________________
11. What treatment did you receive? ________________________________
12. Results of previous treatment? Good ___ Poor ___ Comments ________________
13. Is this condition interfering with Work ___ Sleep ___ Daily Routine ___ Recreation ___
14. Approximate date of last Chiropractic treatment? ________________________________
15. Approximate date of last MD / DO treatment? ________________________________
16. List any other major injuries you have had, other than those mentioned above: ________________

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17. Any other Musculoskeletal problems? No____ Yes____ …Neurological problems? No____ Yes____

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

Patient/Guardian Signature ________________________________ Date: ________________