

Name: _____

Age: _____ Today's Date: _____

Case History

Primary Complaint(s) _____

How long have you had your symptoms?

Days: _____ Months: _____ Weeks: _____

Date of Onset: _____

Was the onset of your symptoms due to any of the following? (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Chronic Symptoms | <input type="checkbox"/> Unknown Onset |
| <input type="checkbox"/> Motor Vehicle Accident | <input type="checkbox"/> Overuse |
| <input type="checkbox"/> Sports/Recreational Activity | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Work Related Injury | <input type="checkbox"/> Other _____ |

What was the onset speed of your injury?

- Gradual? Insidious? Sudden?

Which of the following describes the recent symptom trend? (circle one)

Improving Unchanged Worsening

Have you undergone any of the following diagnostic testing?

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Nerve Conduction Velocity, EMG | <input type="checkbox"/> Blood Test |
| <input type="checkbox"/> Bone Scan | <input type="checkbox"/> CT scan |
| <input type="checkbox"/> Cardiac Stress Test | <input type="checkbox"/> MRI |
| <input type="checkbox"/> Doppler Studies | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Urinalysis/Urodynamics | <input type="checkbox"/> X-rays |
| | <input type="checkbox"/> Other _____ |

Results from above tests: _____

Next Physician Visit? _____

Prior Episodes

Have you had prior episodes of this condition?

- Yes No If yes please answer the following:

How many prior episodes?

- 1 2-3 3-4 4 or more 10 or more

Is the Severity Increasing Decreasing Unchanged

Which treatments have you had for **THIS** condition?

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Bed rest |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Injection |
| <input type="checkbox"/> Massage Therapy | <input type="checkbox"/> Medication |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Other | |

Date of Surgery, if any for this problem: _____

What is your occupation? _____

What is your work status?

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> Full time | <input type="checkbox"/> Regular Duty |
| <input type="checkbox"/> Part time | <input type="checkbox"/> Restricted Duty |
| <input type="checkbox"/> Retired | <input type="checkbox"/> Other |
| <input type="checkbox"/> Unemployed | |

Previous Functional Level

- No limits with activities of daily living
 No limits with work activities
 No limits with recreational activities
 Other _____

What are your goals/reasons for treatment?

For the following activities, check the box next to those that RELIEVE your symptoms.

- | | |
|--|----------------------------------|
| <input type="checkbox"/> Modifying your activities | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Cessation of activity | <input type="checkbox"/> Ice |
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Rest |
| <input type="checkbox"/> Medication | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Walking |

For the following activities, check the box next to those that AGGRAVATE your symptoms.

- | | |
|--|----------------------------------|
| <input type="checkbox"/> Modifying your activities | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Cessation of activity | <input type="checkbox"/> Ice |
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Rest |
| <input type="checkbox"/> Medication | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Walking |

Can you localize your pain? Yes No

If yes, where is your pain? _____

What is the quality of your pain? (check all that apply)

- | | |
|---|------------------------------------|
| <input type="checkbox"/> Dull | <input type="checkbox"/> Radiating |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Sharp |
| <input type="checkbox"/> Pins and Needles | <input type="checkbox"/> Steady |
| <input type="checkbox"/> Pulsating | <input type="checkbox"/> Throbbing |

Pain Scale

- 0 No Pain
- 1 Mild pain: you are aware of it, but it doesn't bother you
- 2 Mild Pain: you become more aware of it, but only begins to bother you
- 3 Moderate Pain that you can tolerate without medication
- 4 More severe pain that requires medication to tolerate
- 5 Severe Pain: you begin to feel antisocial
- 6 Severe Pain: you cannot participate in recreational activities
- 7 Very Severe Pain: you cannot participate in activities of daily living
- 8 Intensely Severe Pain: you cannot leave the house
- 9 Extremely Severe Pain: you cannot get out of bed
- 10 Most Severe Pain: it may make you contemplate suicide

(Using the above scale)

At best? _____ **At worst?** _____

Which best describes your general health?

- | | |
|------------------------------------|-------------------------------|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Fair |
| <input type="checkbox"/> Good | <input type="checkbox"/> Poor |

Is your pain dependent on the time of day?

- Yes No

If yes, what time(s) is better? _____

What time is worse? _____

What is the frequency of your pain?

- Constant
- Intermittent/daily
- Occasional (less than daily)
- Sporadic (less than weekly)

Lifestyle

How would you consider yourself generally?

Sedentary Physically Active

What is your current exercise routine? _____

What activities do you wish to return to? _____

Activity Measures

Please indicate if any of the following activities aggravate your symptoms:

| Activity | Symptoms | After how long |
|----------------------------|--|-----------------------|
| Ascending Stairs | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Bathing | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Carrying more than 25 lbs. | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Carrying up to 25 lbs. | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Childcare | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Defecation | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Descending Stairs | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Deskwork/Computer Use | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Dressing | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Driving | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Exercise | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Grooming | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Housework | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Kneeling | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Lifting more than 25 lbs. | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Lifting up to 25 lbs. | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Reaching across | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Reaching back | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Reaching out | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Reaching up | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Running | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Sexual Intercourse | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Sitting | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Sleeping | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Sport Activity | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Squatting | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Standing | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Urination | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Walking | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Work Activity | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Yardwork | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |

Medical History

| | | | | | |
|----------------------|--|----------------------|--|--------------------------|--|
| Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinsons | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dizzy Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anxiety | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema/Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fractures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gallbladder Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Straining with Urination | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Strokes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cardiac Conditions | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cardiac Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Incontinence | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Urgency with Urination | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulation Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Metal Implants | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vision Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Currently Pregnant | <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Sclerosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Describe any other conditions or precautions: _____

Fall History

Injury as a result of a fall in the past year? Yes No If yes, date of fall: _____

Two or more falls in the last year? Yes No If yes, dates of falls: _____

Surgery History

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Current Medications

Drug: _____ Dosage: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Reason for Taking: _____

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