

Name: _____

Today's Date: _____

Age: _____

Case History

Primary Complaint(s) _____

How long have you had your symptoms?

Days: _____ Months: _____ Weeks: _____ Years: _____

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? (circle one)

Gradual Unknown 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 Tests |
| <input type="checkbox"/> Bone Scan | <input type="checkbox"/> CT Scan |
| <input type="checkbox"/> Cardiac Stress Test | <input type="checkbox"/> MRI |
| <input type="checkbox"/> Doppler Study | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Urinalysis/Urodynamics | <input type="checkbox"/> X-Ray |
| | <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? (Circle one)

0-5 6-10 more than 10

Is the severity Increasing Decreasing Unchanged

Which treatments have you received, or are currently receiving for **THIS** condition?

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Bed Rest |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Injections |
| <input type="checkbox"/> Massage Therapy | <input type="checkbox"/> Medications |
| <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

- | |
|--|
| <input type="checkbox"/> No limits with activities of daily living |
| <input type="checkbox"/> No limits with work activities |
| <input type="checkbox"/> No limits with recreational activities |
| <input type="checkbox"/> Other _____ |
- _____

What are your goals/reason for treatment?

Current Complaints

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

- | | |
|--|---|
| <input type="checkbox"/> Arm/Hand Activities | <input type="checkbox"/> Sport specific activity |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Squatting |
| <input type="checkbox"/> Computer Use | <input type="checkbox"/> Ascending stairs |
| <input type="checkbox"/> Driving | <input type="checkbox"/> Descending stairs |
| <input type="checkbox"/> Kneeling | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Overhead Activity | <input type="checkbox"/> Lying on your back |
| <input type="checkbox"/> Pinching/Grasping | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Lying on your stomach | <input type="checkbox"/> Walking on uneven surfaces |
| <input type="checkbox"/> Reaching | <input type="checkbox"/> Work specific activity |
| <input type="checkbox"/> Lying on Right side | |
| <input type="checkbox"/> Lying on Left side | |
| <input type="checkbox"/> Sitting | |

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 |

Can you localize your pain? Yes No

If yes, where is your pain?

What is the quality/behavior of your pain?

- | | |
|---|------------------------------------|
| <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 |

Is your pain dependent on the time of day?

Yes No

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

What time(s) is it worse? _____

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 going to the Emergency Room |

Using the above scale please rate your pain:

At best: _____ At worst: _____

What is the frequency of your pain?

- | |
|---|
| <input type="checkbox"/> Constant |
| <input type="checkbox"/> Intermittent (daily) |
| <input type="checkbox"/> Occasional (less than daily) |
| <input type="checkbox"/> Sporadic (less than weekly) |

Past Medical History

Have you ever received treatment for any of the following injuries?

- | | |
|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Back |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> Foot/Ankle |
| <input type="checkbox"/> Hand | <input type="checkbox"/> Head |
| <input type="checkbox"/> Hip | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Pelvis |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Other |

If yes, please describe: _____

Have you had any surgeries? Yes No

If yes, please describe: _____

Have you ever been pregnant Yes No

If yes, how many pregnancies? _____

How many children? _____

Number of vaginal births: _____

Number of C-sections: _____

Any complications (please describe): _____

Current Medications: _____

Which of the following describes your general health?

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

Lifestyle: How would you consider yourself generally? Sedentary Physically Active

What is your current exercise routine? _____

What activities do you wish to return to? _____

Have you experienced any of the following?

- Recent Fever/Chills
- Incontinence
- Urgency with urination
- Straining with urination
- Pain with intercourse
- Pain with urination/defecation
- Unexplained Weight Loss
- Nausea/Vomiting
- Dizziness/Vertigo

Please check the following conditions you have experienced:

- | | |
|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney infections |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Blood pressure (high/low) | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Congenital heart defect | <input type="checkbox"/> Osteoporosis/osteopenia |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Persistent cough |
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Difficulty staying asleep | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Feeling tired in the morning | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Gout | <input type="checkbox"/> TB |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Temperature sensitivity (cold/hot) |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Urinary/fecal incontinence |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hemophilia | |
| <input type="checkbox"/> Hepatitis | |
| <input type="checkbox"/> HIV/AIDS | |
| <input type="checkbox"/> Kidney Stones | |