PATIENT CASE HISTORY

HISTORY OF CURRENT CONDITION

Describe Major Complaint: ____

Began When? ____/_____/______ **Describe how this began:**____

____

____

Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: ______________________

How frequent is the complaint present? Off & On / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes *(Describe)*______________________________

Head - Base of Skull / Forehead / Sides-Temple R / L / Both *Leg* - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

Arm – Across Shoulder / Elbow / Hand-Fingers R / L / Both *Other Area:* ______________________________

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: ______________

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: __________________

Which daily activities are being affected by this condition? *(Describe)* _____________________________________

For this CURRENT condition, have you:

- **Received any other treatment?** None / DC / MD / PT / Massage / ER / Other: _______________ **Where?** ______________
- **Had any previous Surgery or Interventions in this area?** *(Describe)*_____________________________________
- **Taken any Medications?** OTC / Prescriptions ____
- **Had any diagnostic testing?** X-rays / MRI / CT / Other: ________________ **When and Where?** ________________

Describe any Secondary Complaints: ____

HEALTH HISTORY – (*PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED*)

Medications:

Allergies to Medications: ***NONE*** *(List)* ___________________

____

Current Medications: ***NONE***

*(Already have a list? We can make a copy.)*_______________________

____

____

____

____

Past Health History: *(Please list any past…)*

Surgeries – Date, Type, and Reason: ***NONE***

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____

____

Major Injuries/Traumas: ***NONE*** ___________________

____

____

____

Major Hospitalizations: ***NONE*** ____________________

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____

Family Health History: *(Please mark N/A if not relevant.)*

List *relevant* major health problems of immediate relatives:

____

____

____

Deaths in immediate family: *(Cause and at what Age?)*

____

____

____

Social and Occupational History:

Level of Education Completed: ___________________

High School / Some College / College Grad. / Post Grad. / Other

Lifestyle: *(Hobbies, Rec. Activities, Exercise, Diet, Work, Vitamins)*

____

____

____

____

Habits:

Cigarettes – *(#/day)* ______________________________

Alcohol – *(amount/day)*____________________________

Coffee/Tea – *(cups/day)*___________________________

Rec. Drugs *(List)*_________________________________

Patient No: ___________

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