PATIENT CASE HISTORY

PATIENT NAME _____ DATE _____
ADDRESS _____ SS # _____
CITY _____ STATE _____ ZIP CODE _____
HOME PHONE _____ CELL PHONE _____
DATE OF BIRTH _____ EMPLOYED BY _____
EMAIL ADDRESS _____ REFERRED BY_____

Please describe to us in your own words the history of your chief complaint. Be specific concerning what you were doing at the time your problem began. Please tell us exactly where your pain lies and how long you've had it…….

_____
_____
_____
_____

What have you done to alleviate your pain?

_____
_____

Please describe your pain to us…..check all that apply:

Constant ____ on/off ____ sharp ____ dull ____ burning ____ tingling ____ numbness ____ localized____
radiates ____ inflamed ____ spasm/tension ____ throbbing ____ Other _____

How would you rate your pain: Mild_____ Moderate_____ Severe_____

Is your pain worse during the day or at night? Day____ Night____ No change with time of day_____

What aggravates your condition; please be specific: _____
_____

What makes your pain feel better; please be specific: _____
_____

Other doctors seen for this condition:_____

Prior surgeries or hospitalizations? Year? _____
_____
_____
_____

List prescription drugs you are presently taking_____
_____
_____
_____

Do you smoke?____ For how long? _____Caffeine intake daily_____ Water intake daily _____

List any serious falls or accidents you've experienced during your lifetime…..please be specific:_____
_____
_____
_____
_____

Patient Signature _____ Date _____