Back to Health Physical Medicine and Rehab
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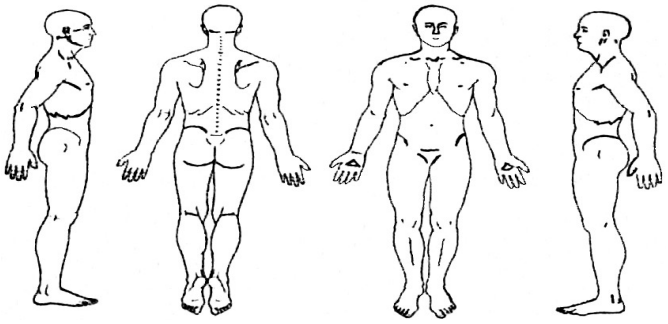
CASE HISTORY

Name: _____

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

List Your Condition / Problems	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
e. _____	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
5. When did your symptoms begin (onset date)? _____
6. How did your symptoms begin? _____
7. Have you experienced these before? _____
8. Do your symptoms radiate? _____
9. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
10. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____
    If No, what have you tried that has not helped? _____
11. Have you been treated for this before? ____No ____Yes How long ago? _____
12. What treatment did you receive? _____
13. Results of previous treatment? ____Good ____Poor Comments _____
14. Were you referred to our office by anyone? _____
15. List any other major injuries you have had, other than those mentioned above: _____

_____

16. Any other Musculoskeletal problems? ____No ____Yes …Neurological problems? ____No ____ Yes
17. List any family history of disease (ie. Father- high blood pressure, Mother- diabetes, etc):_____

_____

18. List any medications you are allergic to:_____

_____Additional information on back side of sheet. Provider/Doctor Signature:_____ Date:_____

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

Patient/Guardian Signature _____ Date: _____