CASE HISTORY

Name_____ Phone_____

Address_____ City_____ State_____ Zip_____

Age_____ Birthdate____/____/____ Social Security_____ Sex____ Status M S W D No. Children____

Occupation_____ Employer_____ Years Employed ____

Employer's Address_____ City_____ State____ Phone_____

Spouse's Name_____ Occupation_____ Employer_____

What Symptoms or Complaints are you having?_____

_____

How long have you had this condition?_____ Have you had this or a similar condition in the past? _____

Other doctors seen for this complaint_____

What treatment did you receive?_____

Have you been off work?_____ How Long?_____

List any **Medications** you are taking_____

List any surgical operations and their dates_____

_____

INDICATE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS BELOW:

Discribe the nature of your symptoms?

___Sharp ___Shooting ___Burning

___Numb ___Dull ___Tingling

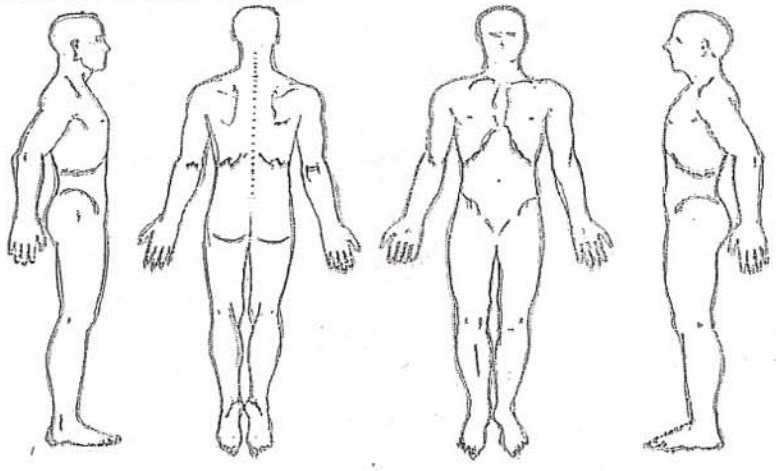
How often do you experience you symptoms?

___Constantly(76-100% of the day)

___Frequently(51-75% of the day)

___Occassionally(26-50% of the day)

___Intermittently(0-25% of the day)



Indicate the average intensity of your symptoms: *None* ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

Do you have a history of:

Smoking?_____ Alcohol use?_____ Substance abuse?_____ Allergies?_____

High Blood Pressure?_____ Diabetes?_____ Cancer?_____

Patient Signature_____ Date_____