

# 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

**Major Injuries/Traumas:** NONE \_\_\_\_\_

**Major Hospitalizations:** NONE \_\_\_\_\_

**Patient No:** \_\_\_\_\_



### 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) \_\_\_\_\_