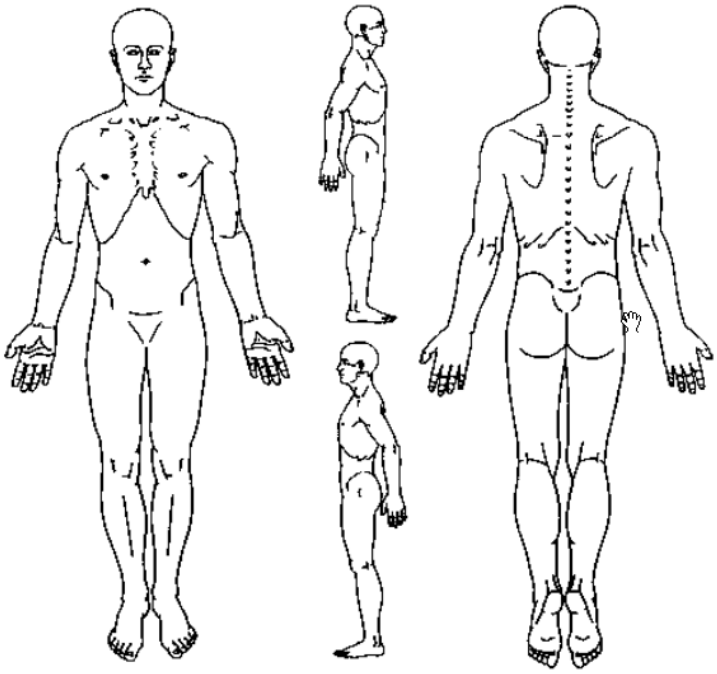
Print Name _____

CURRENT COMPLAINT

CASE HISTORY

Please mark your area of your concern on the diagram below.



SUMMARY:

1. What is your major symptom?

_____

_____

2. What does this prevent you from doing or enjoying?

_____

3. When was the first time you noticed this problem?

_____

How did it happen?

_____

Has it become worse recently? o Yes o No

If yes, when and how?

_____

Have you experienced this before? o Yes o No If yes, when?

_____

4. How frequent is the condition? o Constant o Daily

o Intermittent o Night Only o Other____ _____

How long does it last? o All Day o Few Hours o Minutes

o Other _____

Has your health problem been:

o Improving o Worsening o Staying the Same

5. Do you have arm pain? o Yes o No
6. Do you have arm numbness or tingling? o Yes o No
7. Do you have leg pain? o Yes o No
8. Do you have leg numbness or tingling? o Yes o No
9. Do you have any weakness in your arms or legs? o Yes o No

10. Describe the pain: (circle all that apply) o Sharp o Dull o Numbness o Tingling o Aching o Burning o Stabbing
o Other If other, describe: _____

11. Have you tried anything to relieve the pain? o Yes o No If yes, describe: _____
Did this help? _____
_____

12. What makes the problem worse? o Standing o Sitting o Lying o Bending o Lifting o Twisting o Turning head
o Other If other, describe: _____

13. Do you have difficulty sleeping? o Yes o No Do you sleep on your: o Stomach o Side o Back

14. Are there any other conditions or symptoms that may be related to your major symptom?
o Yes o No If yes, describe:_____
Are there other unrelated health problems? o Yes o No If yes, describe_____
_____

WOMEN ONLY:

15. Are you pregnant or is there any possibility you may be pregnant? o Yes o No o Uncertain

Patient's Signature _____ Date_____

Doctor's Initials_____