CASE HISTORY

NAME (Please print)	DATE
1. Please list your symptoms. If you have more than one please check all that apply. □ Headaches □ Lower back □ Neck □ Upper back □ Mid-back □ Other	
2. Location of symptoms □ Right side □ Left side □ Middle □ Both sides	
3. Headache location □ Forehead □ Temple(s) □ Side(s) of head □ Base of skull □ Around/behind eyes	
4. Please describe your symptoms. □ Ache/sore □ Throbbing □ Burning □ Stiffness □ Shooting □ Cramping □ Pinching □ Pressure from outside-in □ Pressure from inside-out	
5. When do you feel the symptoms? Non-Stop (all of the time) Comes and goes. How often?	
6. How long have you felt your symptoms?	
7. Have the symptoms changed? □ Yes □ No If yes, did it become □ Worse □ Better	
8. What caused your symptoms? Don't know Car accident Work injury Sports injury Date of injury?	
10. Do the symptoms radiate? □ None □ Arm(s) □ Leg(s) □ Right □ Left □ Both □ Upper arm □ Forearm □ Hand □ Fingers □ Buttock □ Thigh □ Lower leg □ Foot □ Toes	
11. Please describe radiating symptom □ Pain □ Numbness □ Tingling	
13. What makes the symptoms better? □ Aspirin/Tylenol □ Ibuprofen □ Pain pills □ Muscle relaxers □ Massage □ Heat □ Cold □ Rest □ Exercise □ Nothing	
12. What makes the symptoms worse? □ Sitting □ Standing □ Driving □ Bending □ Lifting □ Head movement □ Arm movement □ Lying down on: □ Side □ Stomach □ Back	
14. Please rate your pain (10 is worst) \square 1 \square 2 \square 3 \square 4 \square 5 \square 6 \square 7 \square 8 \square 9 \square 10	
(This space for doctor's use. Please leave blank)	
SIGNATURE OF PATIENT	DATE