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?

9. If your symptoms are from an injury, please describe what happened in detail.

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) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

(This space for doctor's use. Please leave blank)

SIGNATURE OF PATIENT	**DATE**