

# Case History

What is your primary complaint? \_\_\_\_\_

When did it start? \_\_\_\_\_

How did it start? \_\_\_\_\_

Have you had this or similar condition in the past? Y / N

My pain is worse when I:

- |  |                                |                                      |
|--|--------------------------------|--------------------------------------|
| <input type="checkbox"/> Cough or Sneeze | <input type="checkbox"/> Lift  | <input type="checkbox"/> Sit         |
| <input type="checkbox"/> Bend forward    | <input type="checkbox"/> Bend  | <input type="checkbox"/> Stand       |
| <input type="checkbox"/> Bend backward   | <input type="checkbox"/> Stoop | <input type="checkbox"/> Walk        |
| <input type="checkbox"/> Turn right      | <input type="checkbox"/> Drive | <input type="checkbox"/> Reach       |
| <input type="checkbox"/> Turn left       |                                | <input type="checkbox"/> Other _____ |

My pain is better when I:

- |  |   |                                      |
|--|---|--------------------------------------|
| <input type="checkbox"/> Lean away from it | <input type="checkbox"/> Stand          | <input type="checkbox"/> Ice         |
| <input type="checkbox"/> Lean toward it    | <input type="checkbox"/> Sit            | <input type="checkbox"/> Heat        |
| <input type="checkbox"/> Lie on my back    | <input type="checkbox"/> Exercise       | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Lie on my stomach | <input type="checkbox"/> After exercise |                                      |

The time my pain is worse in:  Morning  Afternoon  Evening  At night/wakes me up

During work  After work  During exercise  After Exercise

Is this condition interfering with your:  Work  Sleep  Daily routine  Exercise

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What is your secondary complaint (if any)? \_\_\_\_\_

When did it start? \_\_\_\_\_

How did it start? \_\_\_\_\_

Have you had this or similar condition in the past? Y / N

My pain is worse when I:

- |  |                                |                                      |
|--|--------------------------------|--------------------------------------|
| <input type="checkbox"/> Cough or Sneeze | <input type="checkbox"/> Lift  | <input type="checkbox"/> Sit         |
| <input type="checkbox"/> Bend forward    | <input type="checkbox"/> Bend  | <input type="checkbox"/> Stand       |
| <input type="checkbox"/> Bend backward   | <input type="checkbox"/> Stoop | <input type="checkbox"/> Walk        |
| <input type="checkbox"/> Turn right      | <input type="checkbox"/> Drive | <input type="checkbox"/> Reach       |
| <input type="checkbox"/> Turn left       |                                | <input type="checkbox"/> Other _____ |

My pain is better when I:

- |  |   |                                      |
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| <input type="checkbox"/> Lean away from it | <input type="checkbox"/> Stand          | <input type="checkbox"/> Ice         |
| <input type="checkbox"/> Lean toward it    | <input type="checkbox"/> Sit            | <input type="checkbox"/> Heat        |
| <input type="checkbox"/> Lie on my back    | <input type="checkbox"/> Exercise       | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Lie on my stomach | <input type="checkbox"/> After exercise |                                      |

The time my pain is worse is:  Morning  Afternoon  Evening  At night/wakes me up

During work  After work  During exercise  After Exercise

Is this condition interfering with your:  Work  Sleep  Daily routine  Exercise

Other complaint(s)? \_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_