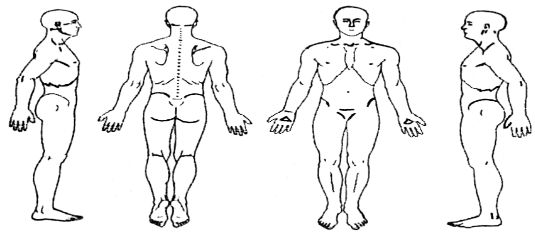
Patient Name ____ Date ______________________________

MT. PLEASANT CHIROPRACTIC & REHAB, LLC

Case History

Please circle the areas on the figures where you experience pain.



How much have your symptoms interfered with usual daily activities?

☐Not at all ☐A little bit ☐Moderately ☐Quite a bit ☐Extremely

Circle actions that make your symptoms worse:

Bending Lying Walking Standing Sitting Movement Twisting Lifting

Conditions/Problem	Severity & Frequency	Type	Onset	Relief & Treatment
	Severity 0=No Pain to 10=Severe 0 1 2 3 4 5 6 7 8 9 10 **Frequency** % of day 0=never to 100=constant 0 10 20 30 40 50 60 70 80 90 100	☐Dull ☐Ache ☐Burn ☐Throb ☐Numb ☐Tingling ☐Sharp Does it radiate? ☐Y ☐N	Symptoms began on: ______/______/__________ Was it?☐Gradual ☐Sudden Has it? ☐Gotten Worse ☐Stayed the same How did symptoms begin? ________________________	Anything to relieve symptoms? ☐Y ☐N If yes:______________ **Prior Treatment?** ☐Y When?__________ ☐N
	Severity 0=No Pain to 10=Severe 0 1 2 3 4 5 6 7 8 9 10 **Frequency** % of day 0=never to 100=constant 0 10 20 30 40 50 60 70 80 90 100	☐Dull ☐Ache ☐Burn ☐Throb ☐Numb ☐Tingling ☐Sharp Does it radiate? ☐Y ☐N	Symptoms began on: ______/______/__________ Was it?☐Gradual ☐Sudden Has it? ☐Gotten Worse ☐Stayed the same How did symptoms begin? ________________________	Anything to relieve symptoms? ☐Y ☐N If yes:______________ **Prior Treatment?** ☐Y When?__________ ☐N
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In general, would you say your overall health right now is…

☐Excellent ☐Very good ☐Good ☐Fair ☐Poor

Please list any health conditions, major illnesses, diseases not mentioned: ____

Please list all past surgeries and/or operations: ____

Please list any medications/supplements currently taking and their purpose: ____________________________________

Do you smoke? ☐No ☐Yes, How much? ____________ Do you drink alcohol? ☐No ☐Yes, How much?______________

Do you drink coffee/caffeinated beverages? ☐No ☐Yes, How much? __________

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