OFFICE USE ONLY

Current Condition Name/Start Date:

_____

Last RE Date: _____

Last Posture Update: _____

Is there an injury we are aware of? Yes No

If yes, what?_____

Is this Auto or Work Comp? Yes No

Is this to possibly release? Yes No

RE because we haven't done a RE: Yes NO

Room Chairside

Case History Update

Date: _____

Name: _____

Has your address changed? ☐Yes ☐No

New Address: _____

Has your phone number changed? ☐Yes ☐No

New Phone Number: _____

Please complete the following – skip if it does not apply

Chief Complaint: _____

Is this a new complaint? ☐Yes ☐No

Was it caused by an injury or accident? ☐Yes ☐No

Condition: ☐New ☐Recurring ☐Exacerbation ☐Other: _____

What date did the accident/injury occur? _____

Where did the accident/injury occur? _____

Is another party responsible for this accident/injury? ☐Yes ☐No

Body Area Involved: ☐Cervical ☐Spine ☐Upper Extremity ☐Lower Extremity

Mechanism of Onset:

☐Auto ☐Slip/Fall ☐Over Exertion ☐Work ☐Repetitive Motion ☐Slept Wrong ☐Unknown

Symptoms: ☐Pain ☐Stiffness ☐Numbness ☐Weakness

Location: ☐Left ☐Right ☐Bilateral

Quality:

☐Burning ☐Dull/Aching ☐Sharp ☐Shooting ☐Stabbing ☐Tightness ☐Radiating ☐Diffuse ☐Localized

☐Throbbing ☐Tingling ☐Other _____

When did the symptoms start? _____

When did they get worse? _____

When did they last occur? _____

When is it worse? ☐Morning ☐Afternoon ☐Evening ☐With Activity ☐Constant ☐Intermittent

Associated Signs:

☐Blurred Vision ☐Headaches ☐Nausea ☐Sleep Disturbance ☐Depression ☐Irritability/Mood Swings

☐Radiating ☐Stiffness ☐Dizziness☐Ringing in ears ☐Localized Tingling

☐Headaches (☐Dull ☐Sharp ☐Throbbing ☐Stabbing ☐Aura ☐No Aura

Other Signs:

☐Aches ☐Fever ☐Numbness ☐Runny Nose ☐Tingling ☐Cold Limb ☐Heartburn ☐Pale Skin

☐Stiffness ☐Vomiting ☐Dizziness ☐Muscle Spasm ☐Panic ☐Sweating ☐Weakness ☐Fatigue

☐Nausea ☐Pins & Needles ☐Swelling

Symptoms Better With:

☐Activity ☐Cold ☐Massage ☐OTC Meds ☐Rest ☐Sitting ☐Twisting ☐Bending ☐Heat ☐Movement

☐RX Meds ☐Stretching ☐Standing ☐Walking ☐Nothing Helps

How often do you still experience symptoms?

☐Constantly (76-100% of the day) ☐Frequently (51-75% of the day)

☐Occasionally (26-50% of the day) ☐Intermittently (0-25% of the day)

What symptoms have improved? _____

Are your symptoms changing? ☐Getting Better ☐Not Changing ☐Getting Worse

What percentage of relief have you received since you first came in?

☐10% ☐20% ☐30% ☐40% ☐50% ☐60% ☐70% ☐80% ☐90% ☐100%

Quality:

☐Burning ☐Dull/Aching ☐Sharp ☐Shooting ☐Stabbing ☐Tightness ☐Radiating ☐Diffuse ☐Localized

☐Throbbing ☐Tingling ☐Other _____

Daily Activities: To What level are you experiencing symptoms while performing these activities?

0 – No Effect →10 – Unable to do *0 – No Effect →10 – Unable to do*

Activity	0	1	2	3	4	5	6	7	8	9	10	Activity	0	1	2	3	4	5	6	7	8	9	10
Bending												***Bathing***											
Carrying Groceries												***Kneeling***											
Change Sit To Stand												***Sleep***											
Child Care												***Sitting***											
Climb Stairs												***Standing***											
Computer Use												***Yard Work***											
Pet Care												***Exercise***											
Driving												***Running***											
Household Chores												***Golf***											
Lifting												***Walking***											
Reading												***Swimming***											
Dressing												***Weight Lifting***											

How does this condition affect job performance?

☐Does not affect job performance ☐Mild (Can Do) ☐Moderate (Limited) ☐Severe (Unable to perform)

Level of Impairment:

Resting:

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain----------Some Pain----------Worst Pain Possible

With Activity:

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain----------Some Pain----------Worst Pain Possible

Please list any other concerns you feel the doctors should be aware of:

_____