|  |
| --- |
| ***OFFICE USE ONLY***  Current Condition Name/Start Date:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last RE Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  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  Posture Update? Yes No |

Case History Update

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Please complete the following – skip if it does not apply

**Chief Complaint:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is this a new complaint?** **Was it caused by an injury or accident?**

☐Yes ☐No ☐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**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_