Taylor Family Wellness Chiropractic
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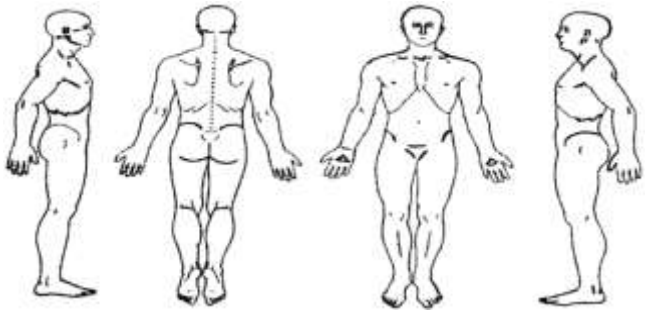
CASE HISTORY

Name: _____

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity (Minimal → Severe)	Frequency (% of week) (Occasional → Constant)
a. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
e. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

(Please mark the figures where you experience pain.)



2. Symptoms are worse in the (circle what applies)

-morning -Increase during the day
-afternoon -same all day
-night -decrease during the day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. When did your symptoms begin (onset date)? _____
6. How did your symptoms begin? _____
7. Have you experienced these before? _____
8. Do your symptoms radiate? _____
9. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
10. Circle the things that make your problems worse:

Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

11. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____
    If No, what have you tried that has not helped? _____
12. Have you been treated for this before? ____No ____Yes How long ago? _____
13. What treatment did you receive? _____
14. Results of previous treatment? ____Good ____Poor Comments _____
15. Were you referred to our office by anyone? _____
16. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation
17. List any other major injuries you have had, other than those mentioned above: _____

_____

18. Any other Musculoskeletal problems? ____No ____Yes …Neurological problems? ____No ____ Yes

19. How do these following activities impact your condition?
    a. Walking: Increase / Decrease Symptoms: I can walk _____ min. before symptoms begin / increase
       additional notes for walking: _____
    b. Sleeping: I have problems falling asleep / staying asleep / wake up stiff & sore in mornings
       additional notes for sleep:_____
    c. Standing: Increase / Decrease Symptoms: I can stand unassisted _____min. before symptoms begin / increase
       additional notes for standing:_____
    d. Lifting: Increase / Decrease Symptoms: I can lift _____lb. with ease / without symptoms
       additional notes for lifting:_____
    e. Bending: Increase / Decrease Symptoms: I can bend easily / have to use assistance / sit to bend
       additional notes for bending:_____
    f. Lying Flat: Increase / Decrease Symptoms: I can lay on Right Side / Back / Left Side Symptom Free
       additional notes for lying:_____
    g. Sitting: Increase / Decrease Symptoms: I can sit _____ min. before symptoms begin
       I go sitting to standing easily/ using my hands to walk up legs / use assistance / no pain / moderate pain/ severe pain
       additional notes for sitting:_____

    h. Any other activity that you currently can't do or that aggravates your symptoms: _____
       _____

20. I am currently utilizing the following activities also to help:
    Massage Nutritional Supplements Prescription Medication Over-the-Counter Medications Exercise Physical Therapy
    additional notes:_____
    _____

21. Current Medications:_____
    _____

22. Current Medical Diagnoses: _____

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date: _____