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CASE HISTORY UPDATE

Name _____ Date _____

Current Address _____

Phone _____ Alt/Work Phone _____

Current complaint for this visit _____

Since last visit, have you had any of the following: Falls _____

Surgery _____ Accidents _____

New Medical Condition(s) or Medications _____

Last Physical? _____ Last visit here? _____

Since my last visit here, I have been seen by Dr. _____ for _____

Insurance _____

Patient comments: _____

Patient Signature

Name _____ Date _____

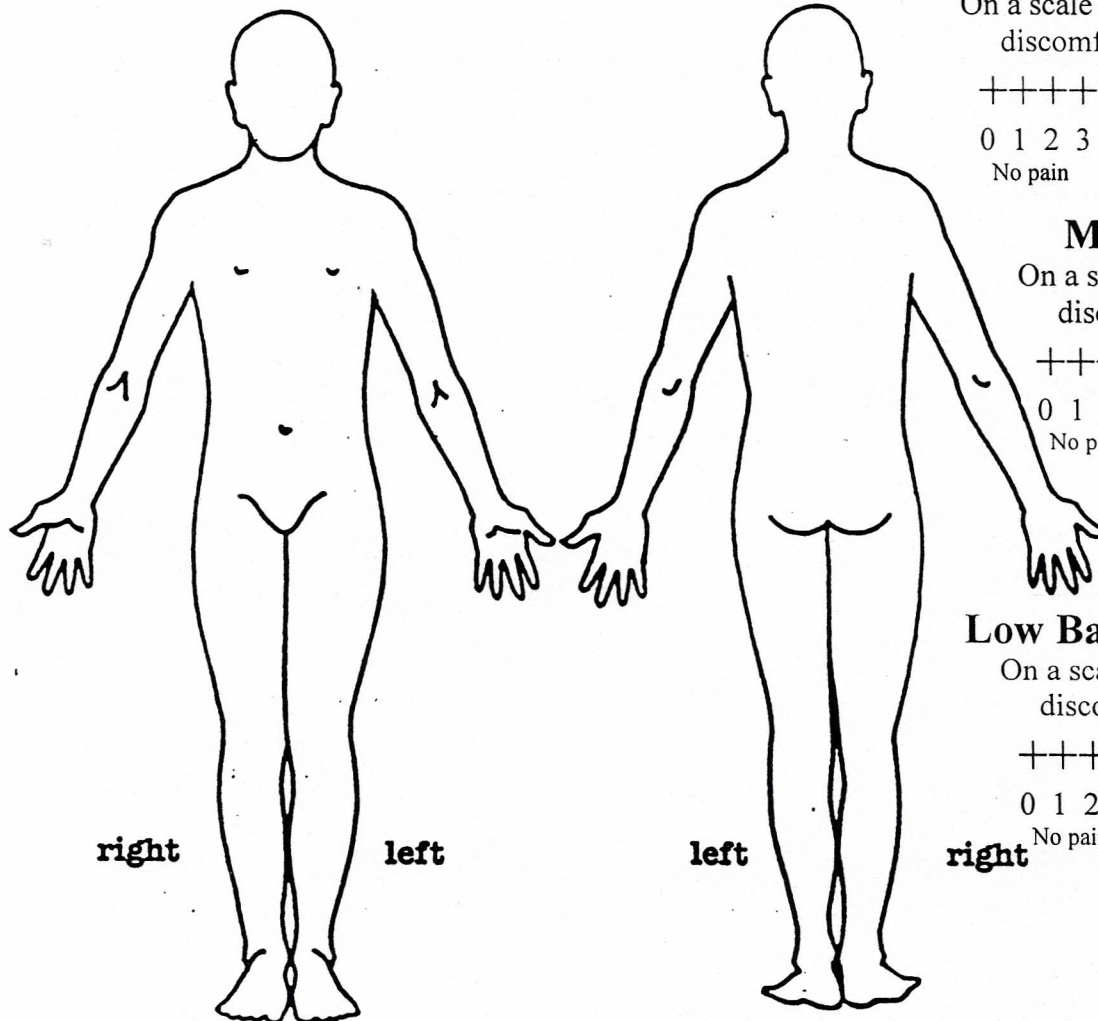
SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations.
 Use the appropriate symbols.
 Mark areas of radiation.
 Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	00000	XXXXX	*****	/////
-----	00000	XXXXX	*****	/////
-----	00000	XXXXX	*****	/////

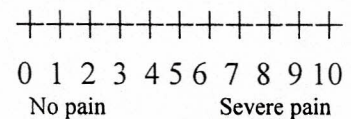
Please mark on the pain scale from zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.

Pain Chart



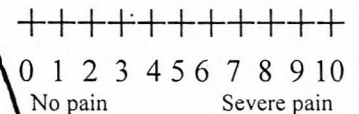
Neck-Shoulder-Arm Pain

On a scale of 0-10, I rate my discomfort as follows:



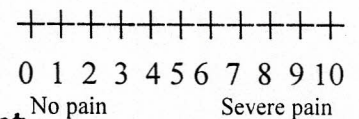
Mid Back Pain

On a scale of 0-10, I rate my discomfort as follows:



Low Back and Leg Pain

On a scale of 0-10, I rate my discomfort as follows:



Date: _____

Signature _____