

CASE HISTORY UPDATE

In order for us to best serve you, and so that we may bring your original case history up to date, please provide us with the following information:

PLEASE PRINT

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell/Work phone: _____

List present complaints and cause (if known): 1. _____

2. _____

3. _____

Duration of present condition: 1. _____

2. _____ 3. _____

Describe any changes in your medical history since your last visit here (falls, surgeries, accidents): _____

Since your last visit here, have you consulted any other doctors? YES/NO. If so, who?

What were you treated for? _____

What type of treatment did you receive? _____

Any other information the doctor should know regarding this condition? _____

Patient's signature

Doctor's comments: _____

ORIGINAL

Mary G. Elsea, D.C. Christopher Rowenhorst, D.C.
 Elizabeth Decker, D.C. Hillary Bauman, D.C.

Patient Name _____
 Date _____

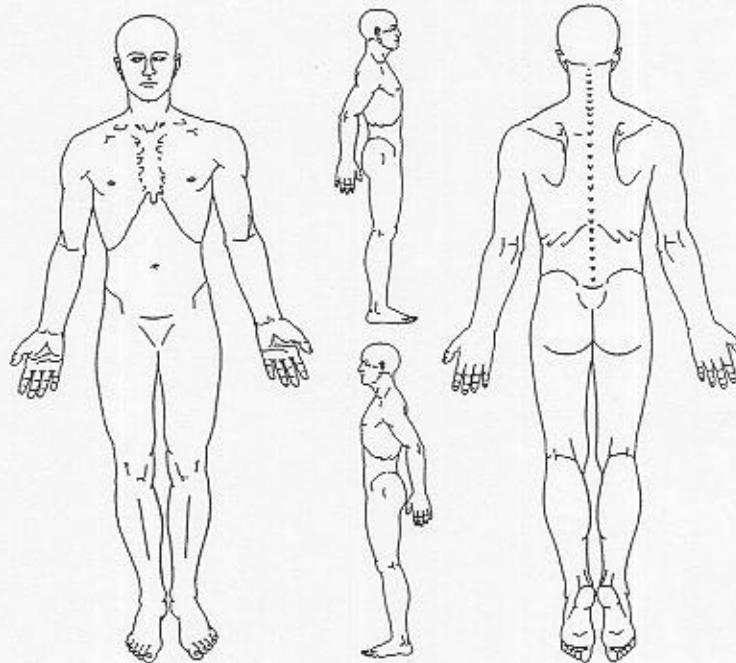
Pain Location, Intensity & Frequency Questionnaire

Reason for Visit: _____
 Other Concerns/Symptoms: _____
 Comments: _____
 When did your symptoms appear? _____
 Have you had similar symptoms in the past? Y N When? _____

Please use the codes below to explain and locate the areas that are bothering you.

KEY

USE LETTERS BELOW TO INDICATE TYPE AND LOCATION OF DISCOMFORT		
A = ACHE	B = BURNING	S = STABBING
N = NUMBING	P = PINS & NEEDLES	O = OTHER



Please rate the **intensity & frequency** of your pain using 0 – 10 Pain scale
 (0=No pain, 10=Most severe imaginable)

Present pain level ____; Average pain level ____; pain present ____% of the time;
 Worst pain level ____, present ____% of the time; lowest pain level ____, present ____% of time.
 What will increase your pain? _____
 What gives you the greatest relief/control of pain? _____
 Is this condition getting progressively worse? Y N Unknown
 Symptoms present in Morning Afternoon Evening Night Constant
 What are you unable to do because of your pain? _____
 What are your goals for this visit? _____

Patient Signature _____ Doctor Signature _____