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To:

WATERTOWN
BACK·CARE

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Patient Case History

A thorough case history is an important part of evaluating your condition and arriving at a diagnosis. Please fill out this form in as much detail as possible. The doctor will review the history with you and answer any question you might have.

PERSONAL DATA

Today's Date:_____

First Name:_____ Last Name:_____ Mid. Init.:_____

Nickname:_____ Date of Birth:_____ Age_____ ☐ M ☐ F

Social Security #_____ Home Phone#_____

Work Phone#_____

Address:_____ City:_____ State:_____ ZIP:_____

Are you: ☐ right handed ☐ left handed ☐ ambidextrous

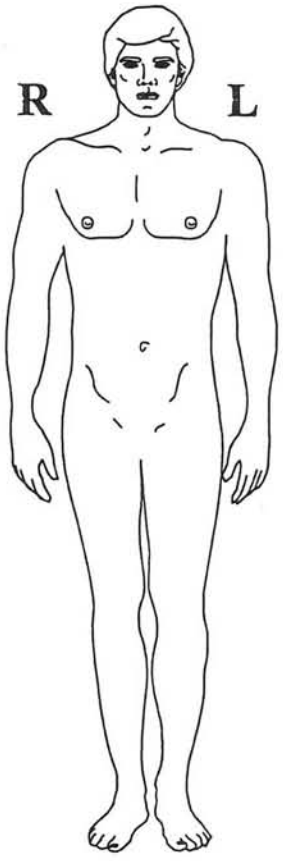
Date of Your Last Physical Examination:_____

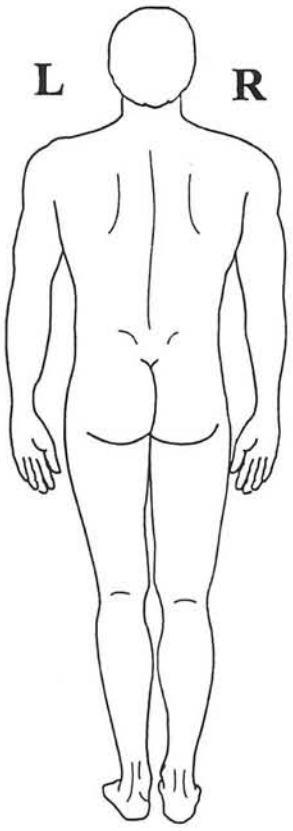
Occupation:_____ Referred By:_____

Patient's Signature:_____
(Guardian if Minor)

Current Complaints

Use the symbols in the box to the right to mark the location and the type of pain or sensations you are feeling.

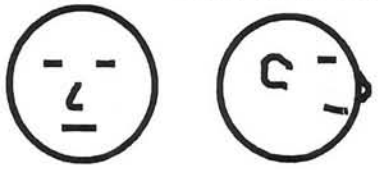




>>>	Aching Pain
XXX	Burning Pain
= = =	Numbness
oooo	Pins & Needles
/////	Stabbing Pain

For Face or Head Pain:

❒ Rt. Side ❒ Lt. Side ❒ Both



The pain / problem began on or about:_____.

How long have you been having the pain?
❒ 1 week or less ❒ 1 to 6 weeks
❒ greater than 6 weeks but less than 3 months
❒ 3 months to 1 year ❒ over 1 year

Please describe your symptoms and list them in order of severity. If you have only one area of complaint, skip numbers 2 through 4.

1. **Area of Pain:**_____

The pain is... ❒ Constant
❒ Intermittent; it usually lasts for _____ ❒ minute(s) ❒ hour(s) ❒ day(s) ❒ week(s)

Please choose the number which best describes your pain in each of the questions below:

What level is your pain RIGHT NOW?

	❒	❒	❒	❒	❒	❒	❒	❒	❒	❒	
No Pain	1	2	3	4	5	6	7	8	9	10	Unbearable Pain

The pain is aggravated by:_____

The pain is relieved by:_____

Fill in numbers 2 through 4 if you have additional areas of complaint.

2. Area of Pain:_____

The pain is... ❒ Constant

❒ Intermittent; it usually lasts for _____ ❒ minute(s) ❒ hour(s) ❒ day(s) ❒ week(s)

Please choose the number which best describes your pain in each of the questions below:

What level is your pain RIGHT NOW?

	❒	❒	❒	❒	❒	❒	❒	❒	❒	❒	
No Pain	1	2	3	4	5	6	7	8	9	10	Unbearable Pain

The pain is aggravated by:_____

The pain is relieved by:_____

3. Area of Pain:_____

The pain is... ❒ Constant

❒ Intermittent; it usually lasts for _____ ❒ minute(s) ❒ hour(s) ❒ day(s) ❒ week(s)

Please choose the number which best describes your pain in each of the questions below:

What level is your pain RIGHT NOW?

	❒	❒	❒	❒	❒	❒	❒	❒	❒	❒	
No Pain	1	2	3	4	5	6	7	8	9	10	Unbearable Pain

The pain is aggravated by:_____

The pain is relieved by:_____

4. Other:_____

In general my symptoms are better in: ❒ AM ❒ Midday ❒ PM.

In general my symptoms are worse in: ❒ AM ❒ Midday ❒ PM.

❒ symptoms do not change with the time of day.

Do you have night pain unrelated to movement? ❒ Yes ❒ No

Do you have constant pain unrelated to movement? ❒ Yes ❒ No

Are your symptoms / condition: ❒ improving ❒ unchanged ❒ getting worse.

Medical History

Do you NOW have any of the following conditions: (MARK IF YES)

❒ Congestive heart failure
❒ Chronic lung disease (including bronchitis or emphysema)
❒ Blindness or trouble seeing, even when wearing glasses
❒ Deafness or trouble hearing
❒ Sugar diabetes (diabetes mellitus)
❒ Allergies
❒ Asthma
❒ Ulcer or gastrointestinal bleeding (not counting hemorrhoids)
❒ Hemorrhoids
❒ Arthritis or rheumatism
❒ Sciatica or chronic back problems
❒ Hypertension or high blood pressure
❒ Angina
❒ Heart attack or myocardial infarction
❒ Stroke
❒ Kidney disease
❒ Cancer
❒ Depression

❒ Other_____

Please list any history of illness, injuries, hospitalizations or surgeries:

Date or Age:________ ☐ Illness/Injury ☐ Hospitalization ☐ Surgery:________________________________
☐ Still have problem ☐ Still suffer occasionally from problem ☐ Complete recovery

Date or Age:________ ☐ Illness/Injury ☐ Hospitalization ☐ Surgery:________________________________
☐ Still have problem ☐ Still suffer occasionally from problem ☐ Complete recovery

Date or Age:________ ☐ Illness/Injury ☐ Hospitalization ☐ Surgery:________________________________
☐ Still have problem ☐ Still suffer occasionally from problem ☐ Complete recovery

Date or Age:________ ☐ Illness/Injury ☐ Hospitalization ☐ Surgery:________________________________
☐ Still have problem ☐ Still suffer occasionally from problem ☐ Complete recovery

Date or Age:________ ☐ Illness/Injury ☐ Hospitalization ☐ Surgery:________________________________
☐ Still have problem ☐ Still suffer occasionally from problem ☐ Complete recovery

List medications you are currently taking, prescribed or over the counter:

1. ________________________________ for ____________________________

2. ________________________________ for ____________________________

3. ________________________________ for ____________________________

4. ________________________________ for ____________________________

5. ________________________________ for ____________________________

Do you have a primary care / family physician? ☐ Yes ☐ No;

If Yes, Name:________________________________ Location / Town:____________________

Have you seen specialist(s) for this condition? ☐ Yes ☐ No

If Yes, Name:________________________________ Location / Town:____________________

If Yes, Name:________________________________ Location / Town:____________________

Social History

Educational Level: ☐ Less than 12 years ☐ High school ☐ 1-4 years of college
☐ Beyond 4 years of college ☐ Professional school

Do you smoke? ☐ No ☐ Yes If yes, how many packs of cigarettes do you smoke per day?
☐ less than ½ pack ☐ ½ to 1 pack ☐ 1 to 2 packs ☐ more than 2 packs

How many cups of coffee or caffeinated drinks do you have per day?_________

Do you consume alcohol? ☐ No ☐ Yes If yes, how many drinks in an average day?
☐ less than 1 ☐ no more than 1 ☐ 1 or 2 drinks ☐ 6 to 8 drinks ☐ more than 8 drinks

Do you have a regular program of exercise? ☐ No ☐ Yes If yes, please note the frequency and type of exercise:

____

List any hobbies or recreational sports you enjoy:

____

Family History

Are you: ❒ Single ❒ Married ❒ Widowed ❒ Divorced;
Do you have children? ❒ Yes ❒ No; If yes, please list them:_____
Check if any of your blood relations has any of the following:

Cancer	❒ No ❒ Yes	Relation: ❒ mother ❒ father ❒ brother ❒ sister ❒ sibling
Tuberculosis	❒ No ❒ Yes	Relation: ❒ mother ❒ father ❒ brother ❒ sister ❒ sibling
Diabetes	❒ No ❒ Yes	Relation: ❒ mother ❒ father ❒ brother ❒ sister ❒ sibling
Heart Trouble	❒ No ❒ Yes	Relation: ❒ mother ❒ father ❒ brother ❒ sister ❒ sibling
High Blood Pressure	❒ No ❒ Yes	Relation: ❒ mother ❒ father ❒ brother ❒ sister ❒ sibling
Stroke	❒ No ❒ Yes	Relation: ❒ mother ❒ father ❒ brother ❒ sister ❒ sibling
Epilepsy	❒ No ❒ Yes	Relation: ❒ mother ❒ father ❒ brother ❒ sister ❒ sibling
Stomach Disorders	❒ No ❒ Yes	Relation: ❒ mother ❒ father ❒ brother ❒ sister ❒ sibling
Asthma	❒ No ❒ Yes	Relation: ❒ mother ❒ father ❒ brother ❒ sister ❒ sibling
Allergy / Hay Fever	❒ No ❒ Yes	Relation: ❒ mother ❒ father ❒ brother ❒ sister ❒ sibling
Headaches	❒ No ❒ Yes	Relation: ❒ mother ❒ father ❒ brother ❒ sister ❒ sibling
Chemical Dependency	❒ No ❒ Yes	Relation: ❒ mother ❒ father ❒ brother ❒ sister ❒ sibling
Arthritis / Gout	❒ No ❒ Yes	Relation: ❒ mother ❒ father ❒ brother ❒ sister ❒ sibling
Back Problems	❒ No ❒ Yes	Relation: ❒ mother ❒ father ❒ brother ❒ sister ❒ sibling

If any of your family members are deceased, please list the cause of death and their age in the following space:

_____

Fill This Section Out If Your Injury Is Related To An Automobile Accident (If not go to the next section)

Date of accident:_____ Hour:_____ ❒ AM ❒ PM
Were you the ❒ driver ❒ passenger: ❒ front seat ❒ back seat; ❒ pedestrian
Were the roads ❒ dry ❒ wet ❒ snowy/icy Were you wearing a seat belt ❒ Yes ❒ No
Were you struck from ❒ behind ❒ driver's side ❒ passenger's side ❒ head on ❒ both front and rear
❒ both front and side ❒ both side and rear
At the time of the impact was your vehicle ❒ stopped ❒ moving forward
Was your air bag deployed ❒ Yes ❒ No
Do you recall any part of your head or body striking any part of the interior of the car ❒ Yes ❒ No

If yes, please describe:_____

_____

Type of vehicle you were in_____ Type of vehicle that struck you_____
Head / body position at time of impact
❒ head turned to left / right ❒ head looking back ❒ head straight forward
❒ body straight in sitting position ❒ body rotated to left / right ❒ other:_____
Did you feel pain ❒ immediately ❒ gradually ❒ next day ❒ other_____
Were you knocked unconscious? ❒ Yes ❒ No If yes, for about how long _____ ❒ second(s) ❒ minute(s)
Did you receive first aid at the scene of the accident? ❒ Yes ❒ No
Did you go to the hospital by ❒ ambulance ❒ a friend ❒ drove yourself
Name of hospital:_____
Did the hospital take x-rays ❒ Yes ❒ No.
What treatment was given_____

_____

Work History / Job Demands

Occupation:

❒ Clerical ❒ Homemaker ❒ Production ❒ Professional / Technical ❒ Service / Retail ❒ Tradesman

❒ Other:_____ Employer:_____

Are you currently able to work? ❒ Yes ❒ No If no, list date(s) out of work:_____

How many hours do you normally work in a week? _____

Work Postures: For this job, fill in hours per day that you usually work in the following postures:

	Max At One Time	Total Hours
Sitting down (office, car, truck, etc.)	_____❒ min. ❒ hrs.	_____
Standing (at a counter, at a machine, etc.)	_____❒ min. ❒ hrs.	_____
Walking while carrying less than 20 lbs.	_____❒ min. ❒ hrs.	_____
Walking while carrying more than 20 lbs.	_____❒ min. ❒ hrs.	_____

	Not At All (never)	Rarely (less than 1/10 of the time)	Occasionally (less than 1/3 of the time)	Frequently (1/3 to 2/3 of the time)	Constantly (more than 2/3 of the time)
How often do you have to kneel or crawl in your work?	❒	❒	❒	❒	❒
How often do you have to lie down (for example, as an auto mechanic) in your work?	❒	❒	❒	❒	❒
How often do you have to squat or remain bent or twisted at the hips in your work?	❒	❒	❒	❒	❒
How often does your work cause vibrations to your whole body?	❒	❒	❒	❒	❒
Do you have to operate a foot pedal?	❒	❒	❒	❒	❒
On this job, how often do you lift:					
10 to 20 pounds	❒	❒	❒	❒	❒
20 to 50 pounds	❒	❒	❒	❒	❒
50 to 100 pounds	❒	❒	❒	❒	❒
More than 100 pounds	❒	❒	❒	❒	❒
On this job, how often do you carry:					
10 to 20 pounds	❒	❒	❒	❒	❒
20 to 50 pounds	❒	❒	❒	❒	❒
50 to 100 pounds	❒	❒	❒	❒	❒
More than 100 pounds	❒	❒	❒	❒	❒
How often do you jump from one level to another? (for example, jumping down from a truck cab or a loading dock)	❒	❒	❒	❒	❒
About how often per day do you climb a flight of steps on this job?	❒	❒	❒	❒	❒

Five ratings of physical demands are described below. Please mark the one which best describes your job.

❒	Sedentary	Sometimes I stand or walk, but I sit down most of the time. Occasionally, I lift up to a 10 pound load.
❒	Light	Any of the following: ▪ I walk or stand more than 1/3 of the time ▪ I often lift up to 10 pounds ▪ I sit down, but often work a foot pedal
❒	Medium	I often lift up to 20 pounds, or sometimes up to 50 pounds
❒	Heavy	I often lift up to 50 pounds, or sometimes up to 100 pounds
❒	Very Heavy	I often lift over 50 pounds, or sometimes over 100 pounds