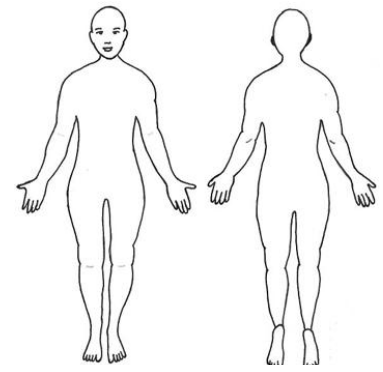


Chronic Pain Solutions—Clinical Case History

Patient Name:

Date:



Mark Areas of ALL Symptoms on the Diagram with an "X"

What is the MAIN condition for which you are consulting with the doctor?

When did your condition begin: Month: Day: Year:

What do YOU think may have caused your main problem(s) to develop?

How would you describe the severity of your condition?	<input type="checkbox"/> EXTREME (Causing limitations more than 80% of the time)
<input type="checkbox"/> SEVERE (Causing significant limitations)	<input type="checkbox"/> MODERATE (Tolerable but definitely causing limitations)
<input type="checkbox"/> MINIMAL (Annoying, but NO limitations)	<input type="checkbox"/> SLIGHT (Tolerable, but causing just a little limitation)

How often are you having your symptoms?	<input type="checkbox"/> Occasionally (25% of the time)
<input type="checkbox"/> Intermittently (50% of the time)	<input type="checkbox"/> Frequently (75% of the time)
<input type="checkbox"/> Constantly (90-100% of the time)	<input type="checkbox"/> Worse as the day progresses
<input type="checkbox"/> Better as the day progresses	<input type="checkbox"/> Same all day long

On a scale of 1-10 (10 = Best), Please Rate Your Level of:

Physical Energy & Vitality:	Mental & Emotional Wellbeing:
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On a Pain Level Scale of 0 – 10 (10 being unbearable, 0 being No Pain or Discomfort) Please rate the following...

The HIGHEST your pain gets WITHOUT medication		The LOWEST it gets WITHOUT medication	
The HIGHEST your pain gets WITH medication		The LOWEST it gets WITH medication	

How has the quality of your life been affected by your condition:

What activities has your condition limited or prevented you from doing?

Has your condition caused you to lose time from work? Yes No How Much?

Has it interfered with household chores and tasks? Yes No How?

Have You Lost Any Time From Your Family? Yes No Time From Fun/Pleasurable Activities? Yes No

If you cannot find a solution to this problem, what do you think will happen to you?

Check the box next to Medical Diagnostic Tests done in an attempt to find the cause of your MAIN condition:

<input type="checkbox"/> X-rays	<input type="checkbox"/> MRI	<input type="checkbox"/> CT Scan	<input type="checkbox"/> Blood Tests
<input type="checkbox"/> Needle EMG (Nerve Test)	<input type="checkbox"/> Orthopedic Tests	<input type="checkbox"/> Bone Density Scan	<input type="checkbox"/> Ultrasound
<input type="checkbox"/> Electro-Dermal Screening	<input type="checkbox"/> Muscle Testing (Kinesiology)	<input type="checkbox"/> Chiropractic Exam	<input type="checkbox"/> Heat Scans
<input type="checkbox"/> Spinal Tap	Other:		

Check the box next to treatments you have tried to get rid of your MAIN condition:

<input type="checkbox"/> Over-the-Counter Drugs (like Tylenol, Aspirin, Advil)	<input type="checkbox"/> Anti-Inflammatory Drugs	<input type="checkbox"/> Muscles Relaxers
<input type="checkbox"/> Cortisone (Steroid) Injections	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Chiropractic
<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Massage	<input type="checkbox"/> Antibiotics
<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Pain Management	<input type="checkbox"/> Electrical Stimulation
<input type="checkbox"/> Surgery (List type and date):		
<input type="checkbox"/> Prescription Pain Medicine	Other:	

My Condition Feels WORSE:

<input type="checkbox"/> Moving or Bending the Joints Involved	<input type="checkbox"/> With Heat	<input type="checkbox"/> With Cold
<input type="checkbox"/> When My Joints Involved are NOT Moving	<input type="checkbox"/> With Humidity	<input type="checkbox"/> With Dry Weather
<input type="checkbox"/> When I Stand Up from Sitting	<input type="checkbox"/> When I Sit Down	<input type="checkbox"/> Walking
<input type="checkbox"/> In the Morning When I Wake Up	<input type="checkbox"/> Outdoors/Open Air	<input type="checkbox"/> Indoors/Closed Air
<input type="checkbox"/> In the Evening—After a Day’s Activity	<input type="checkbox"/> Emotional Stress	<input type="checkbox"/> When I’m Busy
<input type="checkbox"/> At Bedtime When I Lie Down	<input type="checkbox"/> On Rainy Days	<input type="checkbox"/> When I’m NOT Busy

My Condition Feels BETTER:

<input type="checkbox"/> Moving or Bending the Joints Involved	<input type="checkbox"/> With Heat	<input type="checkbox"/> With Cold
<input type="checkbox"/> When My Joints Involved are NOT Moving	<input type="checkbox"/> With Humidity	<input type="checkbox"/> With Dry Weather
<input type="checkbox"/> When I Stand Up from Sitting	<input type="checkbox"/> When I Sit Down	<input type="checkbox"/> Walking
<input type="checkbox"/> In the Morning When I Wake Up	<input type="checkbox"/> Outdoors/Open Air	<input type="checkbox"/> Indoors/Closed Air
<input type="checkbox"/> In the Evening—After a Day’s Activity	<input type="checkbox"/> Emotional Stress	<input type="checkbox"/> When I’m Busy
<input type="checkbox"/> At Bedtime When I Lie Down	<input type="checkbox"/> On Rainy Days	<input type="checkbox"/> When I’m NOT Busy

Check the box next to any PRESCRIPTION MEDICATION you are currently taking for other medical conditions:

<input type="checkbox"/> Thyroid Medication (<input type="checkbox"/> Synthroid?)	<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Anti-Depressant Drugs
<input type="checkbox"/> Osteoporosis (<i>Fosomax, etc.</i>)	<input type="checkbox"/> Cholesterol (Lipitor, etc.)	<input type="checkbox"/> Blood Thinners
<input type="checkbox"/> Acid Reflux (<i>Prevacid, Prilosec, Zantac, etc.</i>)	<input type="checkbox"/> Blood Pressure	<input type="checkbox"/> Pain Medicine
<input type="checkbox"/> Blood Thinners (<i>Coumadin, Plavix, etc.</i>)	<input type="checkbox"/> Muscle Relaxers	<input type="checkbox"/> Headache Medicine
<input type="checkbox"/> Others:		

SKELETAL/JOINTS:

My Joints “Creak & Crack”	<input type="checkbox"/> Neck Pain/Stiffness	<input type="checkbox"/> Pain Between Shoulder Blades	<input type="checkbox"/> Arm Pain(<input type="checkbox"/> R <input type="checkbox"/> L)
<input type="checkbox"/> Shoulder Pain: (<input type="checkbox"/> R <input type="checkbox"/> L)	<input type="checkbox"/> Shoulder Burning	<input type="checkbox"/> “Rotator Cuff” Diagnosis	<input type="checkbox"/> “Frozen Shoulder”
<input type="checkbox"/> Elbow Pain (<input type="checkbox"/> R <input type="checkbox"/> L)	<input type="checkbox"/> Wrist/Hand Pain	<input type="checkbox"/> Finger Numbness/Tingling	<input type="checkbox"/> Middle Back Pain
<input type="checkbox"/> Lower Back Pain	<input type="checkbox"/> Hip Joint Pain (<input type="checkbox"/> R <input type="checkbox"/> L)	<input type="checkbox"/> Painful Tailbone (Coccyx)	<input type="checkbox"/> Knee Pain (<input type="checkbox"/> R <input type="checkbox"/> L)
<input type="checkbox"/> Thigh Pain (<input type="checkbox"/> R <input type="checkbox"/> L)	<input type="checkbox"/> Leg Pain (<input type="checkbox"/> R <input type="checkbox"/> L)	<input type="checkbox"/> Foot/Ankle Pain (<input type="checkbox"/> R <input type="checkbox"/> L)	<input type="checkbox"/> Foot/Toe Pain
<input type="checkbox"/> I have JAW Pain (TMJ)	<input type="checkbox"/> I “grind” my teeth	<input type="checkbox"/> I use a dental “Night Guard”	<input type="checkbox"/> Helps <input type="checkbox"/> Doesn’t Help
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> I have had Gout	<input type="checkbox"/> SPINAL FUSION SURGERY
<input type="checkbox"/> Sciatica (pain down leg):	<input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT side	<input type="checkbox"/> Sciatica Switches Sides	<input type="checkbox"/> Shooting Sciatic Pain
<input type="checkbox"/> Pain Rising from Sitting	<input type="checkbox"/> Sharp pain/muscle cramp	<input type="checkbox"/> Feels Better with Heat	<input type="checkbox"/> Stabbing Pain
Have you EVER had:	<input type="checkbox"/> An Auto Accident?	<input type="checkbox"/> Sports Injury or Fall?	<input type="checkbox"/> Physical Abuse?

SKIN/HAIR/NAILS:

<input type="checkbox"/> Nail Fungus Problems	<input type="checkbox"/> “Ringworm”	<input type="checkbox"/> Eczema	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Warts	<input type="checkbox"/> Acne	<input type="checkbox"/> Rosacea	<input type="checkbox"/> Dandruff
<input type="checkbox"/> Loss of Pigment (Vitiligo)	<input type="checkbox"/> Alopecia (patchy hair loss)	<input type="checkbox"/> My Hair is Thin & Brittle	<input type="checkbox"/> Nails Bitten
<input type="checkbox"/> Nails Split	<input type="checkbox"/> Cracks in skin	<input type="checkbox"/> Scars (List body area):	
	<input type="checkbox"/> Other Skin Problems :		

SLEEP & ENERGY PATTERNS

<input type="checkbox"/> Fatigue/Low Energy	<input type="checkbox"/> Poor Quality Sleep	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Wake Up Tired
<input type="checkbox"/> Wake Up Frequently	<input type="checkbox"/> I sleep well	<input type="checkbox"/> My energy level is good	<input type="checkbox"/> I’m <i>too</i> energetic
<input type="checkbox"/> I take sleep medication	<input type="checkbox"/> I Take Melatonin	Other Info:	

BRAIN, NERVES & BEHAVIORAL

<input type="checkbox"/> Poor Memory	<input type="checkbox"/> Attention Deficit	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Obsessive Compulsive
<input type="checkbox"/> Learning Disabilities	<input type="checkbox"/> Dyslexia	<input type="checkbox"/> Bipolar/Manic Depression	<input type="checkbox"/> Split Personality
<input type="checkbox"/> I suffer depression	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Nervous & Jittery	<input type="checkbox"/> Restless Leg
<input type="checkbox"/> Loss of Coordination	<input type="checkbox"/> Speech Difficulty	<input type="checkbox"/> Tremors	<input type="checkbox"/> Facial Tics or Spasms
<input type="checkbox"/> Bell's Palsy	<input type="checkbox"/> Dizziness or Vertigo	<input type="checkbox"/> Ringing of Ears (Tinnitus)	<input type="checkbox"/> Face Pain

HEADACHES (Check ALL that apply) Frequency: Every Day 4-6x/wk 2-3x/wk 1x/wk 2x/mth

<input type="checkbox"/> Start in my NECK	<input type="checkbox"/> Travel Neck to Head/Eye	<input type="checkbox"/> Light make them worse	<input type="checkbox"/> Right Side of Head
<input type="checkbox"/> Left Side of Head	<input type="checkbox"/> Pain Since Spinal Tap	<input type="checkbox"/> Worse During Menstruation	<input type="checkbox"/> Start in my EYE
<input type="checkbox"/> Worse upon Movement	<input type="checkbox"/> Feel Desperate	<input type="checkbox"/> Diagnosed with Migraines	<input type="checkbox"/> Restless Leg
<input type="checkbox"/> Feel Suicidal with them	<input type="checkbox"/> I need to move around	<input type="checkbox"/> I can point to a specific spot	<input type="checkbox"/> Worse in Morning
<input type="checkbox"/> Medication Helps	<input type="checkbox"/> Medication doesn't help	<input type="checkbox"/> I have RIGHT shoulder pain	<input type="checkbox"/> They never go away
<input type="checkbox"/> Doctors Can't Find a Cause	<input type="checkbox"/> I've tried many drugs	<input type="checkbox"/> I've had them _____ years	<input type="checkbox"/> Pain Since a trauma
<input type="checkbox"/> Cold/Ice Helps	<input type="checkbox"/> Heat/Hot Shower Helps	<input type="checkbox"/> Worse with Stress	<input type="checkbox"/> I've had an MRI/CT Scan

STOMACH, INTESTINAL, DIGESTION & ELIMINATION

<input type="checkbox"/> Acid Reflux/Heartburn	<input type="checkbox"/> Frequent Stomach Aches	<input type="checkbox"/> Excessive Belching	<input type="checkbox"/> Excessive Gas
<input type="checkbox"/> Chron's Disease	<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Celiac Disease
<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> Overweight Problems
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Rectal Bleeding	<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Gallbladder Problems
<input type="checkbox"/> I've had Dysentery	<input type="checkbox"/> I've had Giardia	<input type="checkbox"/> I've had intestinal worms	<input type="checkbox"/> Gastric Bypass
<input type="checkbox"/> Trouble Gaining Weight	<input type="checkbox"/> Other:		

LUNGS, NOSE, BREATHING

<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Frequent Bronchitis	<input type="checkbox"/> I Hyperventilate	<input type="checkbox"/> ASTHMA/Wheezing
<input type="checkbox"/> Loss of Taste or Smell	<input type="checkbox"/> I get shortness of breath	<input type="checkbox"/> I've had Pneumonia	<input type="checkbox"/> I cough a lot
<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> I use sinus medication	<input type="checkbox"/> I get nose bleeds	<input type="checkbox"/> Deviated Septum
<input type="checkbox"/> I am a smoker	<input type="checkbox"/> Tried, but failed to quit	<input type="checkbox"/> Sensitive to odors/chemicals	<input type="checkbox"/> Frequent Sore Throat
<input type="checkbox"/> Laryngitis	<input type="checkbox"/> I catch colds easily	<input type="checkbox"/> I get the flu each year	<input type="checkbox"/> Pain upon breathing

CARDIOVASCULAR SYSTEM

<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Rapid Heartbeat	<input type="checkbox"/> Slow Heartbeat	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Stroke	<input type="checkbox"/> TIA	<input type="checkbox"/> Swollen Ankles	<input type="checkbox"/> Deviated Septum
<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Abdominal aortic aneurysm	<input type="checkbox"/> History of Heart Attack
<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> I have a PACEMAKER	<input type="checkbox"/> Other:	

FEMALE: MENSTRUAL & PMS

<input type="checkbox"/> Irritable	<input type="checkbox"/> Moody	<input type="checkbox"/> PMS improves with Flow	<input type="checkbox"/> Sadness & Depression
<input type="checkbox"/> Find it <i>annoying</i> to be consoled	<input type="checkbox"/> Pelvic Heaviness	<input type="checkbox"/> Jealous Feelings	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Heavy, Prolonged Menstruation	<input type="checkbox"/> Pain & Cramps	<input type="checkbox"/> Early Menstruation	<input type="checkbox"/> Dark Blood
<input type="checkbox"/> Weak During Menstruation	<input type="checkbox"/> Clots	<input type="checkbox"/> Breast Tenderness	<input type="checkbox"/> Leg Pain
<input type="checkbox"/> Headaches During Menstruation	<input type="checkbox"/> Uterine Fibroids	<input type="checkbox"/> Ovarian Cyst (<input type="checkbox"/> Right <input type="checkbox"/> Left)	<input type="checkbox"/> Pain During Sex
<input type="checkbox"/> Pelvic Inflammatory Disease	<input type="checkbox"/> Low/No Sex Drive	<input type="checkbox"/> Infertility	<input type="checkbox"/> Cancer
<input type="checkbox"/> Menopause—HOT FLASHES	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Candida (Yeast Infections)	<input type="checkbox"/> STD

MALE:

<input type="checkbox"/> Enlarged Prostate (BPH)	<input type="checkbox"/> Prostate Cancer	<input type="checkbox"/> Erectile Dysfunction	<input type="checkbox"/> Low Testosterone
<input type="checkbox"/> Testicular Pain	<input type="checkbox"/> Low/No Sex Drive	<input type="checkbox"/> Infertility	<input type="checkbox"/> STD

KIDNEY & URINARY:

<input type="checkbox"/> Pain During Urination	<input type="checkbox"/> Urinary Hesitancy	<input type="checkbox"/> Need to Push Urine Forcefully	<input type="checkbox"/> Blood in Urine
<input type="checkbox"/> Urinary Urgency	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Wake to urinate at night often	<input type="checkbox"/> I get Infections

DIETARY, EXERCISE & SUPPLEMENT HABITS:

<input type="checkbox"/> I take Pro-biotic Supplements	<input type="checkbox"/> I use herbal medicine	<input type="checkbox"/> I DON'T drink plain water much
<input type="checkbox"/> I take vitamin/mineral supplements	<input type="checkbox"/> I need Coffee/Caffeine as a Boost	<input type="checkbox"/> I Drink at Least 8-10 Glasses of Water Daily
<input type="checkbox"/> I use artificial sweeteners	<input type="checkbox"/> I consume a lot of SUGAR	<input type="checkbox"/> I drink alcohol often
<input type="checkbox"/> I drink SODA often	<input type="checkbox"/> I don't eat many vegetables	<input type="checkbox"/> I skip meals often
<input type="checkbox"/> I exercise regularly	<input type="checkbox"/> I Rarely Exercise	<input type="checkbox"/> I don't exercise because of pain and/or fatigue

ALLERGIES & SENSITIVITIES (Check ALL that Apply to You): List Other:

<input type="checkbox"/> Dairy Products - Lactose	<input type="checkbox"/> Grains & Gluten	<input type="checkbox"/> Nuts & Seeds:
<input type="checkbox"/> Vegetables:	<input type="checkbox"/> Fruits:	<input type="checkbox"/> Meats & Fish:
<input type="checkbox"/> Grass & Weeds	<input type="checkbox"/> Pollen	<input type="checkbox"/> Trees
<input type="checkbox"/> Animal Fur & Dander	<input type="checkbox"/> Mold & Mildew	<input type="checkbox"/> Dust
<input type="checkbox"/> I take Allergy Medications	<input type="checkbox"/> I Get Regular Allergy Shots	<input type="checkbox"/> I've NOT had success with any treatment
<input type="checkbox"/> I am sensitive to chemical odors	<input type="checkbox"/> I am sensitive to smoke	<input type="checkbox"/> I seem to be allergic to nearly everything
<input type="checkbox"/> I break out in rashes	<input type="checkbox"/> I would really love allergy help!	<input type="checkbox"/> I am satisfied with current treatments

TICK, SPIDER, INSECT & ANIMAL-RELATED (Check ALL that Apply to You):

<input type="checkbox"/> I've had a TICK bite at some time in my life: Approximate Date:	<input type="checkbox"/> I had a red circular rash after a tick bite	<input type="checkbox"/> I have tested positive for Lyme disease: Approximate Date:
<input type="checkbox"/> I've had "inconclusive" Lyme tests	<input type="checkbox"/> A doctor "ruled out" Lyme with blood tests	<input type="checkbox"/> I don't recall ANY doctor ever mentioning Lyme disease
<input type="checkbox"/> I've never heard of Lyme disease	<input type="checkbox"/> I have taken antibiotics for Lyme	<input type="checkbox"/> I have been to a nutritionist for Lyme
<input type="checkbox"/> I have an outdoor living CAT	<input type="checkbox"/> I have a DOG	<input type="checkbox"/> I swim in FRESH water lakes
<input type="checkbox"/> I've recently had a Spider Bite	<input type="checkbox"/> I get lots of mosquito bites/itch	<input type="checkbox"/> Other:

OTHER (Check ALL that Apply to You):

<input type="checkbox"/> I have a history of CANCER	<input type="checkbox"/> I had had chemotherapy	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> I suffer dry mouth	<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Shingles/Herpes
<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Ear Problems	<input type="checkbox"/> Post Traumatic Stress Disorder (PTSD)
<input type="checkbox"/> History of Mononucleosis	<input type="checkbox"/> Feet/Back of head cold & clammy	

Please list the names of other physicians & other health professionals you currently visit as needed:

Primary Family Physician:	Orthopedist:
Neurologist:	Rheumatologist:
Cardiologist:	Dermatologist:
Gynecologist:	Oncologist:
Psychiatrist:	Pain Management:
Optometrist:	Chiropractor:
Naturopathic Physician:	Dietician/Nutritionist:
Physical Therapist:	Massage Therapist: