Wieging Physical Medicine, LLC

Case History 2021

Name: _____ Acct # (Staff Use) _____

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

LIST CONDITIONS (Most severe symptom 1st)	**SEVERITY** *Minimal* *Severe*	**FREQUENCY(% of week)** *Occasional* *Constant*
#1_____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

Symptom #1 is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles / Radiates

When did this symptom begin (onset date)? _____ How did this symptom begin? _____

#2_____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

Symptom #2 is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles / Radiates

When did this symptom begin (onset date)? _____ How did this symptom begin? _____

#3_____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

Symptom #3 is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles / Radiates

When did this symptom begin (onset date)? _____ How did this symptom begin? _____

Other Symptoms:_____

2. Symptoms are worse (Circle): Morning Afternoon Night Increases during the day Same all day
3. Has your condition (Circle): Improved Gotten Worse Stayed the same since it began
4. Circle the things that make your problems worse:

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

5. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____
6. Have you been treated for this before? ____No ____Yes How long ago? _____
7. What treatment did you receive? _____
8. Results of previous treatment? ____Good ____Poor Comments _____
9. Circle if this condition interfering with: Work Sleep Daily Routine Recreation Other
10. List any other *major* injuries or *major* illnesses you have had, other than those mentioned above: _____

_____

11. Any other: Musculoskeletal problems? ____No ____Yes Neurological problems? ____No ____ Yes

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

Patient/Guardian Signature _____ Date: _____

THIS SPACE RESERVED FOR MEDICAL STAFF AND DOCTORS:

_____

_____

_____