Patient Basic Information

Personal Information:

Last Name:	First Name:	Mid. Init.:
Address:	City, State, Zip:	
Home Phone:	Work Phone:	Social Security No.:
Date of Birth:	Date of Injury/Onset:	
Dominant Hand: ❑ Right ❑ Left ❑ Both		
Insurance Information: Policy Holder (if different than patient):		Policy No.:

1. Description of Accident/Injury/Onset

Enter a full description of the accident, injury or onset in the space below.

2. Your condition during and immediately after injury/onset

Enter the details of your condition during and immediately after your injury/onset.

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type

❑ Car ❑ Station Wagon
❑ Van ❑ Pickup Truck
❑ Large Truck ❑ Bus
Other_____

2. Your position in vehicle

❑ Driver ❑ Front Passenger
❑ Left Rear Passenger
❑ Right Rear Passenger
Other_____

3. What was your vehicle doing at the time of the accident?

❑ Stopped at intersection ❑ Stopped in traffic ❑ Stopped at light
❑ Making a right turn ❑ Making a left turn ❑ Parking
❑ Proceeding along ❑ Slowing down ❑ Accelerating
Other_____

4. Time/Speed/Damage

Time of accident_____
Your vehicle's speed: _____mph
Their vehicle's speed: _____mph
Damage to your vehicle
❑ Mild ❑ Moderate
❑ Totaled

5. Details of Accident

Visibility at time of accident
❑ Poor ❑ Fair ❑ Good

Who hit who/what?
❑ You hit other vehicle
❑ Other vehicle hit you
You hit...(object)
_____

6. Road conditions

Road conditions at time of accident
❑ Icy ❑ Wet ❑ Sandy ❑ Dark ❑ Clean and dry

Point of impact
❑ Head-On ❑ Left Front ❑ Right Front
❑ Read-End ❑ Left Rear ❑ Right Rear

7. Body Position, etc.

Did you see the accident coming: **Yes❑ ❑ No**
Were you braced for the impact? **Yes❑ ❑ No**
Did you have a seat belt on? **Yes❑ ❑ No**
Did you have a shoulder harness on? **Yes❑ ❑ No**

Does your vehicle have headrests? Yes❑ ❑ No
What was the position of your headrest at the time of the impact?
❑ Even with top of head ❑ Even with bottom of head ❑ Middle of neck
What was the direction of your head at the time of the impact?
❑ Facing straight forward ❑ Turned to the right ❑ Turned to the left

Did driver side air bags deploy? **Yes❑ ❑ No** Did passenger side airbags deploy? **Yes❑ ❑ No** Did side airbags deploy? **Yes❑ ❑ No**

8. Additional accident information

In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

9. During the accident:

Did your body strike the inside of your vehicle? **Yes❑ ❑ No**
If yes, describe:_____
Did you lose consciousness during the injury? **Yes❑ ❑ No**
If yes, for how long? _____
Your vehicle's estimated damage? _____
Damage to their vehicle: ❑ Mild ❑ Moderate ❑ Totaled
Did police show up at the scene? **Yes❑ ❑ No**
Was an accident report filled out? **Yes❑ ❑ No**

10. After the accident:

Check off your symptoms right after and a few days following:

❑ Headache	❑ Dizziness	❑ Mid back pain	❑ Cold hands
❑ Neck pain	❑ Nausea	❑ Low back pain	❑ Cold feet
❑ Neck stiffnes	❑ Confusion	❑ Nervousness	❑ Diarrhea
❑ Fainting	❑ Fatigue	❑ Loss of taste	❑ Depression
❑ Ringing in ears	❑ Tension	❑ Toe numbness	❑ Anxious
❑ Loss of smell	❑ Irritability	❑ Constipation	❑ Chest Pain

❑ Pain behind eyes ❑ Shortness of breath ❑ Sleeping problems
Others:_____

11. Emergency Room?

Where did you go after the accident?
❑ Home ❑ Work ❑ Hospital ER ❑ Private Doctor
How did you get there?
❑ Drove self ❑ Somebody else ❑ Ambulance ❑ Police
Were X-rays done? Yes❑ ❑ No **Was lab work done?** Yes❑ ❑ No
Body parts X-rayed?_____
What lab work?_____
The X-rays revealed:_____
Treatments: ❑ Cervical Collar ❑ Ice **Other:**_____
Medications:_____
Follow-up instructions:_____
_____

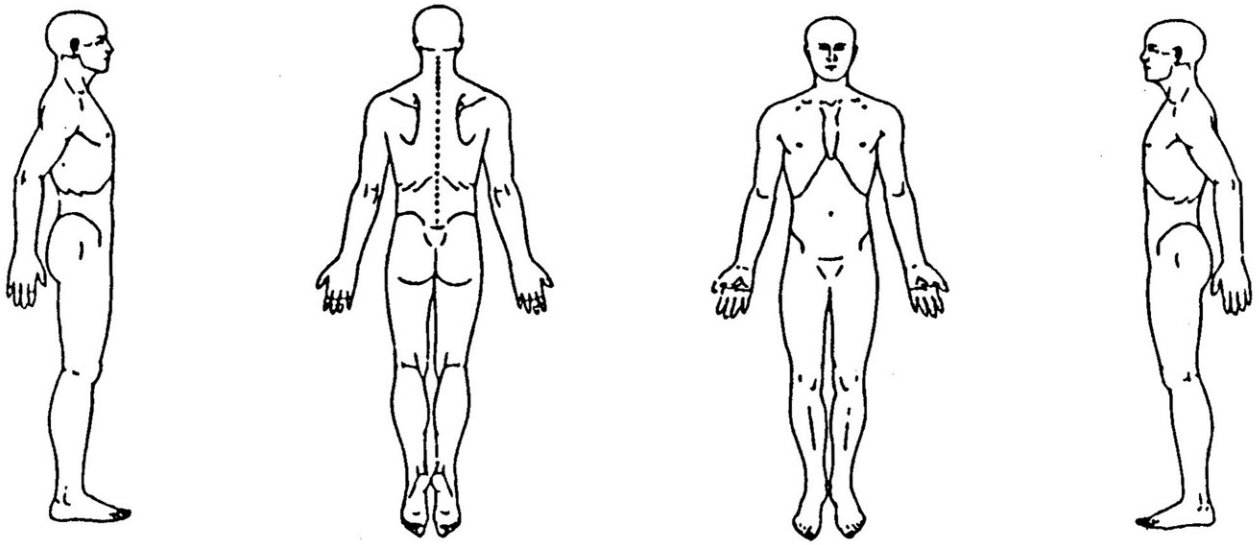
12. Treatment History:

Fill in any other doctor(s) seen prior to your first visit to this office.
1. Dr. _____ First visit date: ____/____/____
Specialty:_____ X-rays done? **Yes❑ ❑ No**
Types of treatments received:_____
How many treatments received? ____ Currently treating? **Yes❑ ❑ No**
Did treatments benefit you? **Yes❑ ❑ No**
Last visit date: ____/____/____
2. Dr. _____ First visit date: ____/____/____
Types of treatments received:_____
How many treatments received? ____ Currently treating: **Yes❑ ❑ No**
Did treatments benefit you? **Yes❑ ❑ No**
Last visit date: ____/____/____

PRESENT COMPLAINTS

1. Please describe the character of your current pain (you may check one or more answers):
   Weakness__ Throbbing/Gnawing__ Numbness__ Shooting__ Gripping/Constricting___
   Burning__ Tingling__
2. How often are the complaints present? Constant (76-100%)__ Frequent (51-75%):___
   Occasional (26-50%):___ Intermittent (25% or less):___
3. How bad is your pain or ache? Please circle a number:
   0 1 2 3 4 5 6 7 8 9 10 (0=no pain, 10=unbearable pain)
4. Since your problem began is the pain: Increasing____ Decreasing____ Not changing____
5. When did your problem begin - specific date if possible_____
6. Did your problem begin: Immediately after a specific incident___ Multiple incidents____
   Gradually developed over time___ No specific reason___
7. Describe how your problem began:_____
   _____
8. What makes your problem better? Nothing___ Lying down____ Walking____ Standing___
   Sitting____ Movement/Exercise____ Inactivity____
9. What makes your problem worse? Nothing____Lying down____ Walking____ Standing___
   Sitting____ Movement/Exercise_____ Inactivity____
10. How would you grade your general stress level? No stress_____ Minimal stress_____
    Moderately stressed_____ Greatly stressed_____
11. Physical activity at work: Sitting more than 50% of workday_____ Light manual labor_____
    Manual labor_____ Heavy manual labor_____
12. General physical activity: No regular exercise program_____ Light exercise program_____
    Strenuous exercise program_____
13. Are your complaints affecting your ability to work or otherwise be active?
    No effect_____ Need limited assistance with common everyday tasks_____
    Have a significant inability to function without assistance_____ Need assistance often_____
    Some physical restrictions (able to perform light duty & household tasks) _____
    Am totally disabled (impaired). Cannot care for self_____ Interferes with sleep_____

MARK AN "X" ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS, INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING



Patients Signature:_____ Date_____

Description of Symptoms (Describe your symptoms in the sections below, in the order of severity, if possible.)

I. First Current Symptom: (Please check off the boxes below to describe your first symptom. Describe only ONE symptom per Section

1. Check only one body location below

Headaches L R B
Front of Head
Top of Head
Back of Head

	L	R	B
Jaw	☐	☐	☐
Eye	☐	☐	☐
Neck	☐	☐	☐
Upper Back	☐	☐	☐
Mid Back	☐	☐	☐
Low Back	☐	☐	☐
Chest	☐	☐	☐
Abdomen	☐	☐	☐
Ribs	☐	☐	☐
Buttocks	☐	☐	☐
Shoulder	☐	☐	☐
Upper Arm	☐	☐	☐
Forearm	☐	☐	☐
Hand	☐	☐	☐
Hip	☐	☐	☐
Leg	☐	☐	☐
Foot	☐	☐	☐

Other locations: _____

2. Types of pain

☐ Dull ☐ Sharp ☐ Aching ☐ Cutting
☐ Throbbing ☐ Burning ☐ Numbing ☐ Tingling ☐ Cramping
☐ Spasm ☐ Stinging ☐ Shooting ☐ Pounding ☐ Constricting

Other types of pain: _____ _____

3. Pain Frequency

☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time
☐ 1/2 to 3/4 of awake time ☐ Most all the time

4. Pain Intensity (How it affects your daily activites)

☐ Doesn't affect ☐ Somewhat affects
☐ Seriously affects ☐ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
Head	☐	☐	☐
Neck	☐	☐	☐
Shoulder	☐	☐	☐
Arm	☐	☐	☐
Hand	☐	☐	☐
Hip	☐	☐	☐
Leg	☐	☐	☐
Foot	☐	☐	☐

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
In the A.M.	☐	☐	☐
In the P.M.	☐	☐	☐
Bending forward	☐	☐	☐
Bending back	☐	☐	☐
Bending left	☐	☐	☐
Bending right	☐	☐	☐
Twisting left	☐	☐	☐
Twisting right	☐	☐	☐
Coughing	☐	☐	☐
Sneezing	☐	☐	☐
Straining	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
	☐	☐	☐

II. Second Current Symptom: (Please check off the boxes below to describe your next symptom).

1. Check only one body location below

Headaches L R B
Front of Head
Top of Head
Back of Head

	L	R	B
Jaw	☐	☐	☐
Eye	☐	☐	☐
Neck	☐	☐	☐
Upper Back	☐	☐	☐
Mid Back	☐	☐	☐
Low Back	☐	☐	☐
Chest	☐	☐	☐
Abdomen	☐	☐	☐
Ribs	☐	☐	☐
Buttocks	☐	☐	☐
Shoulder	☐	☐	☐
Upper Arm	☐	☐	☐
Forearm	☐	☐	☐
Hand	☐	☐	☐
Hip	☐	☐	☐
Leg	☐	☐	☐
Foot	☐	☐	☐

Other locations: _____

2. Types of pain

☐ Dull ☐ Sharp ☐ Aching ☐ Cutting
☐ Throbbing ☐ Burning ☐ Numbing ☐ Tingling ☐ Cramping
☐ Spasm ☐ Stinging ☐ Shooting ☐ Pounding ☐ Constricting

Other types of pain: _____ _____

3. Pain Frequency

☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time
☐ 1/2 to 3/4 of awake time ☐ Most all the time

4. Pain Intensity (How it affects your daily activites)

☐ Doesn't affect ☐ Somewhat affects
☐ Seriously affects ☐ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
Head	☐	☐	☐
Neck	☐	☐	☐
Shoulder	☐	☐	☐
Arm	☐	☐	☐
Hand	☐	☐	☐
Hip	☐	☐	☐
Leg	☐	☐	☐
Foot	☐	☐	☐

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
In the A.M.	☐	☐	☐
In the P.M.	☐	☐	☐
Bending forward	☐	☐	☐
Bending back	☐	☐	☐
Bending left	☐	☐	☐
Bending right	☐	☐	☐
Twisting left	☐	☐	☐
Twisting right	☐	☐	☐
Coughing	☐	☐	☐
Sneezing	☐	☐	☐
Straining	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
	☐	☐	☐

III. Third Current Symptom: (Please check off the boxes below to describe your 3rd symptom).

1. Check only one body location below

Headaches L R B
Front of Head
Top of Head
Back of Head

	L	R	B
Jaw	☐	☐	☐
Eye	☐	☐	☐
Neck	☐	☐	☐
Upper Back	☐	☐	☐
Mid Back	☐	☐	☐
Low Back	☐	☐	☐
Chest	☐	☐	☐
Abdomen	☐	☐	☐
Ribs	☐	☐	☐
Buttocks	☐	☐	☐
Shoulder	☐	☐	☐
Upper Arm	☐	☐	☐
Forearm	☐	☐	☐
Hand	☐	☐	☐
Hip	☐	☐	☐
Leg	☐	☐	☐
Foot	☐	☐	☐

Other locations: _____

2. Types of pain

☐ Dull ☐ Sharp ☐ Aching ☐ Cutting
☐ Throbbing ☐ Burning ☐ Numbing ☐ Tingling ☐ Cramping
☐ Spasm ☐ Stinging ☐ Shooting ☐ Pounding ☐ Constricting

Other types of pain: _____ _____

3. Pain Frequency

☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time
☐ 1/2 to 3/4 of awake time ☐ Most all the time

4. Pain Intensity (How it affects your daily activites)

☐ Doesn't affect ☐ Somewhat affects
☐ Seriously affects ☐ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
Head	☐	☐	☐
Neck	☐	☐	☐
Shoulder	☐	☐	☐
Arm	☐	☐	☐
Hand	☐	☐	☐
Hip	☐	☐	☐
Leg	☐	☐	☐
Foot	☐	☐	☐

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
In the A.M.	☐	☐	☐
In the P.M.	☐	☐	☐
Bending forward	☐	☐	☐
Bending back	☐	☐	☐
Bending left	☐	☐	☐
Bending right	☐	☐	☐
Twisting left	☐	☐	☐
Twisting right	☐	☐	☐
Coughing	☐	☐	☐
Sneezing	☐	☐	☐
Straining	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
	☐	☐	☐

Description of Symptoms

(Describe your symptoms in the sections below, in the order of severity, if possible.)

IV. Fourth Symptom:

(Please check off the boxes below to describe your 4th symptom. Describe only ONE symptom per Section).

1. Check only one body location below

	L	R	B
☐Headaches	☐	☐	☐
☐Front of Head			
☐Top of Head			
☐Back of Head			
☐Jaw	☐	☐	☐
☐Eye	☐	☐	☐
☐Neck	☐	☐	☐
☐Upper Back	☐	☐	☐
☐Mid Back	☐	☐	☐
☐Low Back	☐	☐	☐
☐Chest	☐	☐	☐
☐Abdomen	☐	☐	☐
☐Ribs	☐	☐	☐
☐Buttocks	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Upper Arm	☐	☐	☐
☐Forearm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations: _____

2. Types of pain

Other types of pain: _____

☐ Dull ☐ Sharp ☐ Aching ☐ Cutting
☐ Throbbing ☐ Burning ☐ Numbing ☐ Tingling ☐ Cramping
☐ Spasm ☐ Stinging ☐ Shooting ☐ Pounding ☐ Constricting

3. Pain Frequency

☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time
☐ 1/2 to 3/4 of awake time ☐ Most all the time

4. Pain Intensity (How it affects your daily activites)

☐ Doesn't affect ☐ Somewhat affects
☐ Seriously affects ☐ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
☐ Head	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Shoulder	☐	☐	☐
☐ Arm	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Hip	☐	☐	☐
☐ Leg	☐	☐	☐
☐ Foot	☐	☐	☐

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
☐ In the A.M.	☐	☐	☐
☐ In the P.M.	☐	☐	☐
☐ Bending forward	☐	☐	☐
☐ Bending back	☐	☐	☐
☐ Bending left	☐	☐	☐
☐ Bending right	☐	☐	☐
☐ Twisting left	☐	☐	☐
☐ Twisting right	☐	☐	☐
☐ Coughing	☐	☐	☐
☐ Sneezing	☐	☐	☐
☐ Straining	☐	☐	☐
☐ Standing	☐	☐	☐
☐ Sitting	☐	☐	☐
☐ Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
	☐	☐	☐

V. Fifth Current Symptom:

(Please check off the boxes below to describe your 5th symptom).

1. Check only one body location below

	L	R	B
☐Headaches	☐	☐	☐
☐Front of Head			
☐Top of Head			
☐Back of Head			
☐Jaw	☐	☐	☐
☐Eye	☐	☐	☐
☐Neck	☐	☐	☐
☐Upper Back	☐	☐	☐
☐Mid Back	☐	☐	☐
☐Low Back	☐	☐	☐
☐Chest	☐	☐	☐
☐Abdomen	☐	☐	☐
☐Ribs	☐	☐	☐
☐Buttocks	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Upper Arm	☐	☐	☐
☐Forearm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations: _____

2. Types of pain

Other types of pain: _____

☐ Dull ☐ Sharp ☐ Aching ☐ Cutting
☐ Throbbing ☐ Burning ☐ Numbing ☐ Tingling ☐ Cramping
☐ Spasm ☐ Stinging ☐ Shooting ☐ Pounding ☐ Constricting

3. Pain Frequency

☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time
☐ 1/2 to 3/4 of awake time ☐ Most all the time

4. Pain Intensity (How it affects your daily activites)

☐ Doesn't affect ☐ Somewhat affects
☐ Seriously affects ☐ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
☐ Head	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Shoulder	☐	☐	☐
☐ Arm	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Hip	☐	☐	☐
☐ Leg	☐	☐	☐
☐ Foot	☐	☐	☐

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
☐ In the A.M.	☐	☐	☐
☐ In the P.M.	☐	☐	☐
☐ Bending forward	☐	☐	☐
☐ Bending back	☐	☐	☐
☐ Bending left	☐	☐	☐
☐ Bending right	☐	☐	☐
☐ Twisting left	☐	☐	☐
☐ Twisting right	☐	☐	☐
☐ Coughing	☐	☐	☐
☐ Sneezing	☐	☐	☐
☐ Straining	☐	☐	☐
☐ Standing	☐	☐	☐
☐ Sitting	☐	☐	☐
☐ Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
	☐	☐	☐

VI. Sixth Current Symptom:

(Please check off the boxes below to describe your 6th symptom).

1. Check only one body location below

	L	R	B
☐Headaches	☐	☐	☐
☐Front of Head			
☐Top of Head			
☐Back of Head			
☐Jaw	☐	☐	☐
☐Eye	☐	☐	☐
☐Neck	☐	☐	☐
☐Upper Back	☐	☐	☐
☐Mid Back	☐	☐	☐
☐Low Back	☐	☐	☐
☐Chest	☐	☐	☐
☐Abdomen	☐	☐	☐
☐Ribs	☐	☐	☐
☐Buttocks	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Upper Arm	☐	☐	☐
☐Forearm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations: _____

2. Types of pain

Other types of pain: _____

☐ Dull ☐ Sharp ☐ Aching ☐ Cutting
☐ Throbbing ☐ Burning ☐ Numbing ☐ Tingling ☐ Cramping
☐ Spasm ☐ Stinging ☐ Shooting ☐ Pounding ☐ Constricting

3. Pain Frequency

☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time
☐ 1/2 to 3/4 of awake time ☐ Most all the time

4. Pain Intensity (How it affects your daily activites)

☐ Doesn't affect ☐ Somewhat affects
☐ Seriously affects ☐ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
☐ Head	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Shoulder	☐	☐	☐
☐ Arm	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Hip	☐	☐	☐
☐ Leg	☐	☐	☐
☐ Foot	☐	☐	☐

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
☐ In the A.M.	☐	☐	☐
☐ In the P.M.	☐	☐	☐
☐ Bending forward	☐	☐	☐
☐ Bending back	☐	☐	☐
☐ Bending left	☐	☐	☐
☐ Bending right	☐	☐	☐
☐ Twisting left	☐	☐	☐
☐ Twisting right	☐	☐	☐
☐ Coughing	☐	☐	☐
☐ Sneezing	☐	☐	☐
☐ Straining	☐	☐	☐
☐ Standing	☐	☐	☐
☐ Sitting	☐	☐	☐
☐ Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
	☐	☐	☐

Description of Symptoms

(Describe your symptoms in the sections below, in the order of severity, if possible.)

VII. Seventh Symptom:

(Please check off the boxes below to describe your 7th symptom. Describe only ONE symptom per Section)

1. Check only one body location below

	L	R	B
Headaches	☐	☐	☐
Front of Head			
Top of Head			
Back of Head			
Jaw	☐	☐	☐
Eye	☐	☐	☐
Neck	☐	☐	☐
Upper Back	☐	☐	☐
Mid Back	☐	☐	☐
Low Back	☐	☐	☐
Chest	☐	☐	☐
Abdomen	☐	☐	☐
Ribs	☐	☐	☐
Buttocks	☐	☐	☐
Shoulder	☐	☐	☐
Upper Arm	☐	☐	☐
Forearm	☐	☐	☐
Hand	☐	☐	☐
Hip	☐	☐	☐
Leg	☐	☐	☐
Foot	☐	☐	☐

Other locations: _____

2. Types of pain

☐ Dull ☐ Sharp ☐ Aching ☐ Cutting
☐ Throbbing ☐ Burning ☐ Numbing ☐ Tingling ☐ Cramping
☐ Spasm ☐ Stinging ☐ Shooting ☐ Pounding ☐ Constricting

Other types of pain: _____

3. Pain Frequency

☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time
☐ 1/2 to 3/4 of awake time ☐ Most all the time

4. Pain Intensity (How it affects your daily activites)

☐ Doesn't affect ☐ Somewhat affects
☐ Seriously affects ☐ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
Head	☐	☐	☐
Neck	☐	☐	☐
Shoulder	☐	☐	☐
Arm	☐	☐	☐
Hand	☐	☐	☐
Hip	☐	☐	☐
Leg	☐	☐	☐
Foot	☐	☐	☐

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
In the A.M.	☐	☐	☐
In the P.M.	☐	☐	☐
Bending forward	☐	☐	☐
Bending back	☐	☐	☐
Bending left	☐	☐	☐
Bending right	☐	☐	☐
Twisting left	☐	☐	☐
Twisting right	☐	☐	☐
Coughing	☐	☐	☐
Sneezing	☐	☐	☐
Straining	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
	☐	☐	☐

VIII. Eighth Current Symptom:

(Please check off the boxes below to describe your 8th symptom).

1. Check only one body location below

	L	R	B
Headaches	☐	☐	☐
Front of Head			
Top of Head			
Back of Head			
Jaw	☐	☐	☐
Eye	☐	☐	☐
Neck	☐	☐	☐
Upper Back	☐	☐	☐
Mid Back	☐	☐	☐
Low Back	☐	☐	☐
Chest	☐	☐	☐
Abdomen	☐	☐	☐
Ribs	☐	☐	☐
Buttocks	☐	☐	☐
Shoulder	☐	☐	☐
Upper Arm	☐	☐	☐
Forearm	☐	☐	☐
Hand	☐	☐	☐
Hip	☐	☐	☐
Leg	☐	☐	☐
Foot	☐	☐	☐

Other locations: _____

2. Types of pain

☐ Dull ☐ Sharp ☐ Aching ☐ Cutting
☐ Throbbing ☐ Burning ☐ Numbing ☐ Tingling ☐ Cramping
☐ Spasm ☐ Stinging ☐ Shooting ☐ Pounding ☐ Constricting

Other types of pain: _____

3. Pain Frequency

☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time
☐ 1/2 to 3/4 of awake time ☐ Most all the time

4. Pain Intensity (How it affects your daily activites)

☐ Doesn't affect ☐ Somewhat affects
☐ Seriously affects ☐ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
Head	☐	☐	☐
Neck	☐	☐	☐
Shoulder	☐	☐	☐
Arm	☐	☐	☐
Hand	☐	☐	☐
Hip	☐	☐	☐
Leg	☐	☐	☐
Foot	☐	☐	☐

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
In the A.M.	☐	☐	☐
In the P.M.	☐	☐	☐
Bending forward	☐	☐	☐
Bending back	☐	☐	☐
Bending left	☐	☐	☐
Bending right	☐	☐	☐
Twisting left	☐	☐	☐
Twisting right	☐	☐	☐
Coughing	☐	☐	☐
Sneezing	☐	☐	☐
Straining	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
	☐	☐	☐

IX. Ninth Current Symptom:

(Please check off the boxes below to describe your 9th symptom).

1. Check only one body location below

	L	R	B
Headaches	☐	☐	☐
Front of Head			
Top of Head			
Back of Head			
Jaw	☐	☐	☐
Eye	☐	☐	☐
Neck	☐	☐	☐
Upper Back	☐	☐	☐
Mid Back	☐	☐	☐
Low Back	☐	☐	☐
Chest	☐	☐	☐
Abdomen	☐	☐	☐
Ribs	☐	☐	☐
Buttocks	☐	☐	☐
Shoulder	☐	☐	☐
Upper Arm	☐	☐	☐
Forearm	☐	☐	☐
Hand	☐	☐	☐
Hip	☐	☐	☐
Leg	☐	☐	☐
Foot	☐	☐	☐

Other locations: _____

2. Types of pain

☐ Dull ☐ Sharp ☐ Aching ☐ Cutting
☐ Throbbing ☐ Burning ☐ Numbing ☐ Tingling ☐ Cramping
☐ Spasm ☐ Stinging ☐ Shooting ☐ Pounding ☐ Constricting

Other types of pain: _____

3. Pain Frequency

☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time
☐ 1/2 to 3/4 of awake time ☐ Most all the time

4. Pain Intensity (How it affects your daily activites)

☐ Doesn't affect ☐ Somewhat affects
☐ Seriously affects ☐ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
Head	☐	☐	☐
Neck	☐	☐	☐
Shoulder	☐	☐	☐
Arm	☐	☐	☐
Hand	☐	☐	☐
Hip	☐	☐	☐
Leg	☐	☐	☐
Foot	☐	☐	☐

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
In the A.M.	☐	☐	☐
In the P.M.	☐	☐	☐
Bending forward	☐	☐	☐
Bending back	☐	☐	☐
Bending left	☐	☐	☐
Bending right	☐	☐	☐
Twisting left	☐	☐	☐
Twisting right	☐	☐	☐
Coughing	☐	☐	☐
Sneezing	☐	☐	☐
Straining	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
	☐	☐	☐

Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty: **1** = "I can do it without any difficulty" **2** = "I can do it without much difficulty, despite some pain", **3** = "I manage to do it by myself, despite marked pain", **4** = "I manage to do it, despite the pain, but only if I have help", **5** = "I cannot do it at all, because of the pain". **NOTE: Only fill in areas that are affected.**

Difficulties with Self Care and Personal Hygiene Activities

Bathing ___	Drying hair ___	Brushing teeth ___	Putting on shoes ___	Preparing meals ___	Taking out trash ___
Showering ___	Combing hair ___	Making bed ___	Tying shoes ___	Eating ___	Doing laundry ___
Washing hair ___	Washing face ___	Putting on shirt ___	Putting on pants ___	Cleaning dishes ___	Going to toilet ___

Difficulties with Physical Activities

Standing ___	Walking ___	Kneeling ___	Bending back ___	Twisting left ___	Leaning back ___
Sitting ___	Stooping ___	Reaching ___	Bending left ___	Twisting right ___	Leaning left ___
Reclining ___	Squatting ___	Bending forward ___	Bending right ___	Leaning forward ___	Leaning right ___
Standing for long periods ___		Sitting for long periods ___		Walking for long periods ___	Kneeling for long periods ___

Difficulties with Functional Activities

Carrying small objects ___	Lifting weights off floor ___	Pushing things while seated ___	Exercising upper body ___
Carrying large objects ___	Lifting weights off table ___	Pushing things while standing ___	Exercising lower body ___
Carrying brief case ___	Climbing stairs ___	Pulling things while seated ___	Exercising arms ___
Carrying large purse ___	Climbing inclines ___	Pulling things while standing ___	Exercising legs ___

Difficulties with Social and Recreational Activities

Bowling ___	Jogging ___	Swimming ___	Ice Skating ___	Competitive Sports ___	Dating ___
Golfing ___	Dancing ___	Skiing ___	Roller Skating ___	Hobbies ___	Dining out ___

Difficulties with Travelling

Driving a motor vehicle ___	Riding as a passenger in a motor vehicle ___	Riding as a passenger on a train ___
Driving for long periods of time ___	Riding as a passenger on an airplane ___	Riding as a passenger for long periods ___

Use the following **1 to 5** scale to describe the difficulties below:
1 = "This area is not affected by my condition", **2** = "This area is slightly affected by my condition", **3** = "My condition moderately restricts my ability in this area", **4** = " My condition seriously limits my ability in this area", **5** = "My condition prevents me from using this ability"

Difficulties with Different Forms of Communication

Concentrating____ Hearing____ Listening____ Speaking____ Reading____ Writing____ Using a keyboard____

Difficulties with the Senses

Seeing____ Hearing____ Sense of touch____ Sense of taste____ Sense of smell____

Difficulties with Hand Functions

Grasping____ Holding____ Pinching____ Percussive movements____ Sensory discrimination____

Difficulties with Sleep and Sexual Function

Being able to have normal, restful nights sleep____ Being able to participate in desired sexual activity____

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

Prior Symptom History

Prior Similar Symptoms

- ☐ I have NOT had prior symptoms similar to my current complaints.
- ☐ My current complaints DID exist before, but have not been bothering me.
- ☐ My current complaints ALREADY existed and were worsened.

Has your History Contributed to your Current Symptoms?

- ☐ My history HAS contributed to my current symptoms.
- ☐ My history HAS NOT contributed to my current symptoms.
- ☐ I'm NOT SURE if my history has contributed to my current symptoms.

My most recent prior similar symptoms (**if applicable**) occured____ ☐ months ago / ☐ years ago **Or on** Date:____/____/____

Write in below any other Prior Symptom History, not covered above:

Patient Health History

Today's Date [/ /] **Signature of Patient** _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____ **Suffix** _____

Address 1 _____

Address 2 _____

City_____ **State**_____ **Zip Code** _____

Primary Phone _____ **Secondary Phone** _____

Mobile Phone _____

Home email _____ **Work Email** _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth [/ /] **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑ Samoan	❑ Guamanian or Chamorro	❑ Other_____	❑ I choose not to specify

Multi-Racial *(check one)* ❑ Yes ❑ No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

Continued ...

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary?

Verification Answer to the Chosen question: _____
Answers must be at least 6 characters.

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

	Start Date		Start Date
1) _____		5) _____	
2) _____		6) _____	
3) _____		7) _____	
4) _____		8) _____	

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) _____ 3) _____

2) _____ 4) _____

Briefly list your main health problems: _____

_____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: _____

_____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your <u>low back</u> spine in the past 28 days? ❑ Yes ❑ No

To be performed by clinic staff:

Height: _____inches **Weight:** _____ pounds **BP:** _____ / _____