Patient Basic Information

Personal Information:

Last Name:	First Name:	Mid heat			
		Mid. Init.:			
Address:	City, State, Zip:				
Home Phone:	Work Phone:	Social Security No.:			
Date of Birth:	Date of Injury/Onset:				
ominant Hand: 🔲 Right 🔘 Left 🔘 Both					
Insurance Information: Policy Holder (if different than patient):		Policy No.:			
Description of Accident/ Enter a full description of the accident, in	Injury/Onset njury or onset in the space below.				
		The state of the s			
_	nd immediately after injury				
		•			

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	2. Your position in vehicle	3. What was your vehicle doing at the time of the accident?					
☐ Car ☐ Station Wagon ☐ Van ☐ Pickup Truck ☐ Large Truck ☐ Bus Other	☐ Driver ☐ Front Passenger ☐ Left Rear Passenger ☐ Right Rear Passenger Other		☐ Stopped at intersection ☐ Making a right turn ☐ Proceeding along Other	☐ Stopped in traffic ☐ Stopped at light ☐ Making a left turn ☐ Parking ☐ Slowing down ☐ Accelerating			
4. Time/Speed/Damage	5. Details of Accident		6. Road conditions				
Time of accident	Visibility at time of accident □ Poor □ Fair □ Goo Who hit who/what? □ You hit other vehicle □ Other vehicle hit you You hit(object)		Road conditions at time of a Icy	accident y			
7. Body Position, etc.							
Did you see the accident comin Were you braced for the impac Did you have a seat belt on? Did you have a shoulder harner Did driver side air bags deploy? 8. Additional accident informat In the case of a motor vehicle acc	t? Yes □ No Yes □ No ss on? Yes □ No Yes □ No Yes □ No Did passenger	What U F side ai	t was the position of your ven with top of head Even t was the direction of your acing straight forward Turbags deploy? Yes No	headrests? Yes \(\text{\tint{\text{\tint{\text{\ticl{\text{\ticl{\text{\tex{\tex			
9. During the accident:			10. After the accident:				
Did your body strike the inside of If yes, describe: Did you lose consciousness during If yes, for how long? Your vehicle's estimated damage: Damage to their vehicle: Did police show up at the way an accident report	ng the injury? Yes \(\text{No} \) No Mild \(\text{Moderate} \) Moderate \(\text{Total} \) Total he scene? Yes \(\text{No} \)	 taled	☐ Headache ☐ Dizzine ☐ Neck pain ☐ Nausea ☐ Neck stiffnes ☐ Confus ☐ Fainting ☐ Fatigue ☐ Ringing in ears ☐ Tensior ☐ Loss of smell ☐ Irritability	Low back pain Cold feet ion Nervousness Diarrhea Loss of taste Depression Toe numbness Anxious			
11. Emergency Room?			12. Treatment History:				
Where did you go after the acc Home Work How did you get there? Drove self Somebody else Were X-rays done? Yes DN Body parts X-rayed? What lab work? The X-rays revealed: Treatments: Cervical Collar Medications:	ospital ER Private Doctor Delice Delice Vas lab work done? Yes Delice Other:	□ No 	1. Dr	d? Currently treating? Yes ☐ No Yes ☐ No / First visit date://			
Follow-up instructions:		_	Did treatments benefit you? Last visit date:/	Yes□□ No			

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 possible6. 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 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
151 17514(1) 171 13(1)
The state of the s
1.

Date_

Patients Signature:

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											
First Curre Check only	nt Symp	tom: (Ple	ase check below	off the boxes b	elow to des	scribe your	first symptor	 Describe only ONE 			
□Headaches	L 🛄	R 🗖	В□	Dull	□ Sharp	☐ Achi	na 🗀 C	utting	Otne	r types o	отраіп:
	Front of He Top of Hea			☐Throbbing	☐ Burning	g 🚨 Num	nbing 🖵 Ti	ngling			
	Back of He	ad		□Spasm	☐ Stingin	g 🚨 Shoo	oting 🔲 Po	ounding Constrictin		,	
□Jaw	r 🗖	R 🛄	ВО	3. Pain Freque		□1/4 to	1/2 of time	6. Actions affecting	-		.
□Eye □Neck	L 🗆	R □ R □	В 🛄 В 🔲	1/2 to 3/4 of				☐ In the A.M.	ngs On A	Aggravates	Relieves
☐ Upper Back	נ ם	R 🗆	ВО	- 1,2 10 0, 101			20 U IC UITIC	☐ In the P.M.		ā	
☐Mid Back	L 🗆	R 🗆	в□	4. Pain Intens							
LowBack	LΠ	R 🔲	ВП	Doesn't affe		Somewhat Prevents a		☐ Bending back ☐ Bending left			Н
☐ Chest ☐ Abdomen	L 🔲	R □ R □	В 🔾 В 🔾					I Diponie i i i i i	H	H	
Ribs	1 0	R	ВО	5. Does this p	ain radiate Left		body parts? Both	Twisting left			0000000000
☐ Buttocks	L 🗆	R 🗖	в 🗖	☐ Head		Right	Both	Twisting right			
Shoulder	ΓÖ	R 🗆	ВО	☐ Neck				☐ Coughing☐ Sneezing		片	片
UpperArm □Forearm	L 0	R 🗆 R 🗔	B □ B □	Shoulder				☐ Straining	000	0000	<u> </u>
☐Hand	ίä	RO	вО	☐ Arm ☐ Hand			ā	☐ Standing			ā
□Hip	L 🔲	R 🔲	в 🚨	Hip	ă	ă	ă	Sitting			
Leg	ΓÜ	R 🔲	В	☐ Leg				☐ Lifting OtherActions:			Ч
☐Foot Other locations	. L 🗖	R 🗆	В□	Foot				Other Actions:			
	-			Other locatio						ā	ā
II. Second Cu			halaw			es below to	describe you	r next symptom).			
Check only only only only only only only only	L 🔲	R 🔲	B □	2. Types of pa		-	_		Other	r types o	f pain:
	Front of He	ead	I	☐ Dull☐Throbbing	☐ Sharp ☐ Burning	☐ Achir Num					
	Top of Hea			Spasm	☐ Stinging			ngling	~		
□ □ □ i	Back of He	ead R□	вП	3. Pain Freque	ncy			6. Actions affecting		in	
Eye	ដើ	Ř□	В 🔲 В 🔲	Up to 1/4 of a	wake time	□ 1/4 to	1/2 of time	Brin		Aggravates	
□Neck	L 🛄	R 🛄	В□	□ 1/2 to 3/4 of	awake time	☐ Most a	Ill the time	☐ In the A.M. ☐ In the P.M.			
Upper Back Mid Back	L 0	R □ R □	В 🔲 В 🔲	4. Pain Intensi	i ty (How it a	ffects your	daily activites		ă		000
□LowBack	ίū	R	B	Doesn't affe	ct 🗆	Somewhat	affects	Bending back			
☐ Chest	īŌ	R 🗖	в	Seriously aff	ects 🖵	Prevents a	ctivities	Bending left			00
Abdomen	ΓÖ	R 🗆	ВП	5. Does this p			body parts?	☐ Bending right ☐ Twisting left	ä	H	
☐ Ribs ☐ Buttocks	L 🛄	R □ R □	В 🛄 В 🔲	D. 114	Left	Right	Both	Twisting right	ă	ă	<u> </u>
Shoulder	[]	RO	ВО	☐ Head ☐ Neck				☐ Coughing	ũ	□	ā
□UpperArm	īŌ	R 🗖	в	Shoulder	ā	ō		☐ Sneezing	000000	000000	0000000
Forearm	L 🔲	R 🗆	в 🖵	□Arm			ā	☐ Straining ☐ Standing	Н	Н	
Hand	L 🖸	R 🔲	ВП	Hand			00000	Sitting	ä	<u> </u>	
□Hip □Leg	L 🔲	R □ R □	B 🔲	☐ Hip ☐ Leg				Lifting	ā	ā	<u> </u>
Foot	נֿ 🗖	Ř□	В 🔲 В 🛄	Foot	ă		ă	OtherActions:			
Other locations	s :			Other location	s of radiat	ion:					
III. Third Curr	ent Symp	otom:	(P	lease check off	the boxes b	elow to des	cribe your 3rd	symptom).			
 Check only o □Headaches 	ne body id	ocation be	elow B □	2. Types of pa					Other	types of	f pain:
	ront of Hea			Dull Dull	☐ Sharp	Achir					
	op of Head			☐ Throbbing ☐ Spasm	☐ Burning ☐ Stinging		bing ☐ Tir	ngling	. —		
Jaw UB	lack of Hea	ad Rロ	в□	3. Pain Freque		, 000	ung war o	6. Actions affecting		in	
□Eye	10	R 🗆	В	☐Up to 1/4 of a	wake time		1/2 of time			uggravates	Relieves
□Neck	L 🛄	R 🔲	в 🔲 📗	☐ 1/2 to 3/4 of a	awake time	☐ Most a	II the time	☐ In the A.M.			
Upper Back	LO	R 🔲	ВО	4. Pain Intensi	fv (How it at	ffects vour	taily activites	In the P.M.			
☐Mid Back ☐LowBack	L 🗆	R □ R □	В О В О	☐ Doesn't affe		Somewhat		☐ Bending forward ☐ Bending back			
Chest	נ ם	R 🗆	ва	Seriously aff	ects 🔲 I	Prevents ac	tivities	Bending left	ă	ă	ă
Abdomen	LQ	R 🔲	в口і	5. Does this pa	ain radiate	into other	body parts?	Bending right	000000		
Ribs	r 🖸	R 🗆	В	D.U.	Left	Right	Both	Twisting left Twisting right			
☐ Buttocks ☐ Shoulder	L 🖸	R 🔲 R 🔲	В 🔲 В 🔲	☐ Head ☐ Neck				Coughing	5	ä	7
UpperArm	ι σ	R 🗖	ва	Shoulder			ä	☐ Sneezing	ā	ā	ă
□Forearm	Г 🗖	R 🔲	в 🔾	□Arm				☐ Straining		000000000	
Hand	L 🔲	R 🔲	ВП	Hand				Standing			
□Hip □Leg	L 🔲	R □ R □	В 🔾 В 🔾	☐ Hip ☐ Leg				☐ Sitting☐ Lifting			0000000000
Foot	נַ ם	R 🗖	В	☐ Foot	<u> </u>	ă	ä	Other Actions:			
Other locations		_		Other location							

Description of Symptoms	(Describe your symptoms in the sections below				
IV. Fourth Symptom: (Please check 1. Check only one body location below	off the boxes below to describe your 4th symptom 2. Types of pain	. Describe only ONE s			
☐Headaches L☐ R☐ B☐	1	412	Other	types c	of pain:
☐ Front of Head	Dull Sharp Aching Cu				
☐ Top of Head☐ Back of Head☐		unding Constricting			
□Jaw L□ R□ B□	3. Pain Frequency	6. Actions affecting	this p	pain	
□Eye L□ R□ B□	☐ 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	Bring In the A.M.	gs On Ag		Relieves
Neck L R B	172 to 5/4 of awake time 12 Most all the time	☐ In the P.M.	ä		
☐UpperBack L☐ R☐ B☐ ☐Mid Back L☐ R☐ B☐	4. Pain Intensity (How it affects your daily activites)	☐ Bending forward		ā	ā
OLowBack LO RO BO	☐ Doesn't affect ☐ Somewhat affects	Bending back			
□Chest L□ R□ B□	☐ Seriously affects ☐ Prevents activities	Bending left			
□Abdomen L□ R□ B□	5. Does this pain radiate into other body parts?	Bending rightTwisting left		Н	H
ORibs LOROBO	Left Right Both	Twisting right		ä	ă
□ Buttocks L□ R□ B□ □ Shoulder L□ R□ B□	Head D D	Coughing Coughing	<u> </u>	ō	ā
UpperArm L R B	□ Neck □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	☐ Sneezing		000000000	000000000000
□Forearm L□ R□ B□	OArm O O	☐ Straining			
□Hand L□ R□ B□	Hand D D	☐ Standing☐ Sitting		H	H
OHip LOROBO	D Hip	Lifting	ō	ā	_
ULeg L R B B	Leg	OtherActions:		_	_
Other locations :	Other locations of radiation:				
V. Fifth Current Symptom:	(Please check off the boxes below to describe	our 5th symptom).			
1. Check only one body location below	2. Types of pain		Other	types	of pain:
☐ Headaches L ☐ R ☐ B ☐ . ☐ Front of Head	☐ Dull ☐ Sharp ☐ Aching ☐ Cu				
☐ Top of Head	☐ Throbbing ☐ Burning ☐ Numbing ☐ Till	ngling			
☐ Back of Head	☐ Spasm ☐ Stinging ☐ Shooting ☐ Po	unding Constricting 6. Actions affecting	a this	nain	
□Jaw L□ R□ B□ □Eye L□ R□ B□	Up to 1/4 of awake time 1/4 to 1/2 of time	Brings	On Agg		Relieves
□Eye L□ R□ B□ □Neck L□ R□ B□	☐ 1/2 to 3/4 of awake time ☐ Most all the time	☐ In the A.M.			
UpperBack L R R B B	A Dain leteralty (Hawit effects your daily activity	☐ In the P.M.☐ Bending forward			
☐Mid Back L☐ R☐ B☐	4. Pain Intensity (How it affects your daily activites ☐ Doesn't affect ☐ Somewhat affects	Bending back	ă	ä	ä
□LowBack L □ R □ B □ □Chest L □ R □ B □	☐ Seriously affects ☐ Prevents activities	☐ Bending left	00	000000	
□Abdomen L □ R □ B □	5. Does this pain radiate into other body parts?	☐ Bending right			
□Ribs L□ R□ B□	Left Right Both	☐ Twisting left☐ Twisting right	000	ŏ	000
□Buttocks L□ R□ B□ □Shoulder L□ R□ B□	Head	☐ Coughing	ā	ā	ā
Shoulder L R B B U		☐ Sneezing			
□Forearm L□ R□ B□	Ì□Arm □ □ □	Straining Standing			
☐Hand L☐ R☐ B☐	Hand	Standing Sitting	H	<u>.</u>	ä
□Hip L□ R□ B□ □Leg L□ R□ B□		Lifting		亩	ā
□Leg L □ R □ B □ □Foot L □ R □ B □	Groot Groot	OtherActions:		_	_
Other locations:	Other locations of radiation:				
VI. Sixth Current Symptom: (Please check off the boxes below to describe your	6th symptom).			
1. Check only one body location below	2. Types of pain		Other	types	of pain:
☐Headaches L ☐ R ☐ B ☐ ☐Front of Head	Dull Sharp Aching C				
☐ Top of Head	☐Throbbing ☐ Burning ☐ Numbing ☐ Till ☐Spasm ☐ Stinging ☐ Shooting ☐ Po	ngling			
☐ Back of Head	3. Pain Frequency	6. Actions affecting		———	
□Jaw L□ R□ B□ □Eye L□ R□ B□	☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time		On Agg		Relieves
□Neck L□ R□ B□	☐ 1/2 to 3/4 of awake time ☐ Most all the time	☐ In the A.M.		Ö	
UpperBack L R B B	4. Pain Intensity (How it affects your daily activities	☐ In the P.M.☐ Bending forward			
☐Mid Back L☐ R☐ B☐ ☐LowBack L☐ R☐ B☐	☐ Doesn't affect ☐ Somewhat affects	Bending back			<u> </u>
□Chest L□ R□ B□	☐ Seriously affects ☐ Prevents activities	☐ Bending left	ā		$\bar{\Box}$
□Abdomen L□ R□ B□	5. Does this pain radiate into other body parts?	Bending right			
Ribs L R B B	Left Right Both	Twisting left	Н		
☐ Buttocks L ☐ R ☐ B ☐ ☐ Shoulder L ☐ R ☐ B ☐	Head	☐ Twisting right ☐ Coughing	70	ä	7
UpperArm L R R B B	Shoulder	☐ Sneezing	ā	ā	ō
□Forearm L□ R□ B□	Arm D D	☐ Straining	000000000		
□Hand L□ R□ B□	□ Hand □ □ □	Standing		0000000	<u>ה</u>
□Hip L□ R□ B□ □Leg L□ R□ B□	Hip	Sitting Lifting	<u> </u>		00000000000
Groot LG RG BG	Groot G	Other Actions:			
Other legations:	Other locations of radiation:	1			

Description				(Describe you	r symptoms	in the sec	tions below,	in the ord	ler of severity,	if pos	sible.)	
VII. Seventh S			ase check	off the boxes t		scribe your	7th sympto	n. Descri	be only ONE			
□Headaches	L 🖸 İ	R 🔲	В 🗆	2. Types of Dull	pain Sharp	☐ Ach	· 🗇 (٠		Other	r types	of pain:
	Front of He Fop of Hea			Throbbing		g □ Nun	וחש חוות מים nbina	Cutting Fingling	☐ Cramping			
	op of nea Back of He			☐ Spasm	Stingin			ounding	☐ Constricting	,		
□Jaw	L	R 🔲	в 🛄	3. Pain Frequ	uency			6. Acti	ions affecting	g this		
□ Eye	L 🗓	R 🔲	ВО	Up to 1/4 of 1/2 to 3/4 of	awake time	U 1/4 to	1/2 of time	☐ in th	Bring	gs On A	ggravates	Relieves
□ Neck □ Upper Back		R 🗆 R 🗆	В 🔲 В 🔲					🗐 🖵 In th	ie A.ivi. ie P.M.	ä	<u> </u>	
☐Mid Back	L 🛄	R 🗆	вО	4. Pain Intens				s] 🖵 Ben	ding forward			
LowBack	r 🖺	R 🔲	В	Doesn't aff		Somewhat		☐ Ben	iding back			
☐Chest ☐Abdomen	L 🔲	R □ R □	В 🛄 В 🛄	☐ Seriously at		Prevents a		Ben	iding left iding right		ם כ	
☐ Ribs	L 🚨	R 🔲	в 🚨	5. Does this p	ain radiate is Left	nto other be Right	ody parts? Both	☐ Twis	sting left		ō	ō
Buttocks	L 🖸	R 🔲	в 🔾	☐ Head				☐ Twis	sting right		0000	0000000000
□Shoulder □UpperArm	L 🗆	R □ R □	В 🛄 В 🛄	☐ Neck				□ Sne	gning ezina	ם ם	ם כ	
☐ Forearm	L 🛄	R 🚨	ВО	☐ Shoulder ☐ Arm				☐ Strai	ining			ā
Hand	L	R 🔲	в 🗖	☐ Hand				☐ Stan	nding			
□Hip □Leg	L 🔲	R 🗆 R 🗇	В 🔾 В 🔾	Hip D Local		8		Sittin				H
Foot	ίä	R 🗆	ВО	☐ Leg					Actions:			_
Other locations				Other location			-					
VIII. Eighth C	urrent S	vmptom:		(Please ched			to describe	your 8th	symptom)		<u> </u>	
1. Check only o	ne body	location b		2. Types of p	pain	<u> </u>	10 0000	7001 011.	Symptomy.	Other	types	of pain:
☐Headaches ☐F	L ☐ Front of He	R ロ ead	в	Dull Dull	☐ Sharp	Achi		Cutting				
<u></u> 1	Γop of Hea	ad	ŀ	☐ Throbbing ☐ Spasm	BurningStinging	g □ Num g □ Shoo			☐ Cramping ☐ Constricting	. —		
□Jaw	Back of He	ead R□	в 🗆	3. Pain Frequ	uency				ions affecting		pain	
□ Eye	L 🗆	R 🔾	ВО	Up to 1/4 of	awake time	□ 1/4 to	1/2 of time		Brings	On Agg	gravates I	
□Neck	L	R 🚨	ВО	□ 1/2 to 3/4 of	awake time	Most a	all the time	□ In th	e A.M. ∽ P.M			
☐ Upper Back ☐ Mid Back	L 🔲	R □ R □	В 🛄 В 🛄	4. Pain Intens				s) 🖵 Bend	ding forward	00	100	<u> </u>
□LowBack	Ī 🗖	R 🛄	в 🔲	Doesn't affe		Somewhat		☐ Ben	ding back			Ö
Chest	r 🗖	R 🔲	ВП	☐ Seriously at		Prevents a			ding left ding right	000000	000000	00000000000
☐ Abdomen ☐ Ribs	Γ ()	R □ R □	В 🔲 В 🔲	5. Does this pa	ain radiate in Left	ito other bo Right	ody parts? Both	│ □ Twis	sting left	ā	ā	ă
Buttocks	L 🔲	R 🔲	в□	☐ Head		Kignt	Botu		sting right			
Shoulder	L 🔲	R 🔲	в 🔲	Neck				☐ Cou			Н	
□UpperArm □Forearm	L 🖸	R □ R □	В 🔾 В 🔾	☐ Shoulder ☐ Arm				☐ Strai		<u> </u>	ă	Ğ
Hand	L	R 🗆	В	☐ Hand				Stan				<u> </u>
□Hip	L 🛄	R 🛄	в 🖵 📗	☐ Hip			ā	Sittir				
□Leg □Foot		R □ R □	B □ B □	Leg Foot			00000		ng Actions:		_	
Other locations		·	B 🖫	Other location			u .					
IX. Ninth Curre	ent Symi	ntom:	(F	Please check of			describe vou	r 9th sym	intom)			—
1. Check only or	ne body k	ocation be	wole	2. Types of p	oain		100000 700	, our cylli	ptonij.	Other	types o	of pain:
□Headaches □Fi	L ☐ ront of Hea	R □ ad	в□	☐ Dull	☐ Sharp	🔲 Achi		utting				
□To	op of Head	d	ļ	☐Throbbing ☐Spasm	☐ Burning ☐ Stinging	, —			☐ Cramping ☐ Constricting			
□ Ba □ Jaw	ack of Hea	ad R □	в□	3. Pain Frequ		1 - 01100	And CIT		ons affecting		——	
Eye	Ĭ 🗖	R 🗖	В	☐ Up to 1/4 of a	awake time	□ 1/4 to	1/2 of time		Brings		pann pravates F	Relieves
□Neck	L 🖸	R 🔲	в□	1/2 to 3/4 of	awake time	☐ Most a	ıll the time	In the	e A.M.			
□UpperBack □MidBack	L 🔲	R □ R □	В 🔾	4. Pain Intens	itv (Howita	ffects vour	daily activites	In the	e P.M. ding forward			
□LowBack	. 0	R 🗆	В	Doesn't affe	ect 🗆 🤅	Somewhat	affects		ding back			ă
☐ Chest	L	R 🚨	В□	Seriously af		Prevents ac		🔟 🗖 Bend	ding left			
□ Abdomen □ Ribs	L 0	R □ R □	В 🔲 В 🔲	5. Does this pa				☐ Bend	ding right sting left		00000000	
Buttocks	נ <u>ื</u>	R	ва	☐ Head	Left	Right	Both		sting right		ă	<u> </u>
Shoulder	L 🔲	R 🔲	в□	□ Neck				Coug	ghing			<u> </u>
□UpperArm □Forearm	L 🔲	R 🔲 R 🗇	В 🔲 В 🗔	☐ Shoulder ☐ Arm				☐ Snee			H	
Hand	נֿם	R 🗖	в	Hand	ă		ä	Stan			ă	ā l
Hip	L 🖸	R 🔲	в🛛 📗	☐ Hip			ā	☐ Sittir	ng			
□Leg □Foot	LO	R □ R □	В 🔲 В 🔲	☐ Leg ☐ Foot			00000	Other A	ng Actions:			u
Other locations:		Α 🚨	5 u	Other location			u	Othera	todons.			

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
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
Difficulties with Travelling Driving a motor vehicle
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 Writing Using a keyboard Difficulties with the Senses
Seeing 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. I'm NOT SURE if my history has contributed to my current symptoms.
My most recent prior similar symptoms (if applicable) occured
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 _____State____Zip Code _____ City _____ 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 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 ☐ Korean ☐ Japanese □ Vietnamese ☐ Native Hawaiian or other Pacific Island □Samoan ☐ Guamanian or Chamorro □Other____ □ I choose not to specify 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 ☐ Vietnamese ☐ Italian □ Tagalog ☐ Korean ☐ Russian ☐ Polish ☐ Arabic ☐ Portuguese ☐ Japanese ☐ French Creole ☐ Greek ☐ Hindi ☐ Persian ☐ Urdu ☐ Guiarati □ Armenian ☐ I choose not to specify

Continued ...

Verification Question (choose only one question	on by circling t	the question, then give the answ	er to that question)	
□ What is the name of your favorite pe□ What is your favorite movie?□ What was the make of your first car?	et? 🔲 In w hat is your r	what city were you born?		
Verification Answer to the Chosen ques	tion:	ers must be at least 6 characters		
Do you currently smoke tobacco of any If yes, how often do you smoke:	kind? 🔲 \	Yes □ Former smoker very day smoker □ Cu		er
If yes, what is your level of interest i □ 0 □ 1 □ 2 □ 3 No interest		smoking?	9 10 Very Interested	
Current medications, including frequence check here:		age if known. If there ar	e no current medicatio	ons,
1)	Start Date	E\		Start Date
2)		5)		-
3)		6)		
4)		7) 8)		
If no allergies are known, check here: 1) 2)				
2)		÷		
Has any doctor diagnosed you with Hype	ertension p	presently? 🗆 Yes 🗅 No	If yes, describe:	
Has any doctor diagnosed you with Diab If yes to Diabetes, was your blood la If yes, other comments regarding Dia Have you had an X-ray or CT scan or MR	b-work tes abetes:	t for hemoglobin A1c >	9.0%7 🗆 Yes 🗔 No	
To be performed by clinic staff:				
Height:inches Weigh	ıt:	pounds BP:		

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