

Patient Basic Information

Personal Information:

Last Name:	First Name:	Middle Initial:
Address:	City, State, Zip:	
Home Phone:	Work Phone:	Social Security No.:
Date of Birth:	Date of Injury/Onset:	
Dominant Hand: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> 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.

*** If this is an automobile accident, you can go to the next page. If you would like to describe it more fully, use the boxes above and below to fully describe your accident, injury or onset.**

2. During and after accident details

Enter the details of your condition during and after the accident/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
 Rear-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**
Was your shoulder harness on? **Yes** **No**
Did driver side airbag deploy? **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 passenger side airbag deploy? **Yes** **No** Side airbags? **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 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 following the accident:

Headache Dizziness Mid back pain Cold hands
 Neck pain Nausea Low back pain Cold feet
 Neck stiffness 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?
 Self Somebody else Ambulance Police
X-rays done? **Yes** **No** **Lab work?** **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 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: ____/____/____

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

I. Current Symptom: (Please check off the boxes below to describe your 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

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

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 daily activities)

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

5. Does this pain radiate into other body parts?

- | | Left | Right | Both |
|-----------------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Neck | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Arm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hand | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hip | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Leg | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Foot | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other locations of radiation: _____

6. Actions affecting this pain

- | | Brings On | Aggravates | Relieves |
|--|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> In the A.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> In the P.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending forwrd. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending back | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Twisting left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Twisting right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Straining | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Standing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other Actions: _____

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

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

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 daily activities)

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

5. Does this pain radiate into other body parts?

- | | Left | Right | Both |
|-----------------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Neck | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Arm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hand | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hip | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Leg | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Foot | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other locations of radiation: _____

6. Actions affecting this pain

- | | Brings On | Aggravates | Relieves |
|--|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> In the A.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> In the P.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending forwrd. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending back | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Twisting left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Twisting right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Straining | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Standing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other Actions: _____

III. Current Symptom: (Please check off the boxes below to describe your next 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

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

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 daily activities)

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

5. Does this pain radiate into other body parts?

- | | Left | Right | Both |
|-----------------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Neck | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Arm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hand | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hip | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Leg | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Foot | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other locations of radiation: _____

6. Actions affecting this pain

- | | Brings On | Aggravates | Relieves |
|--|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> In the A.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> In the P.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending forwrd. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending back | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Twisting left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Twisting right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Straining | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Standing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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 all, because of the pain".
Only fill in areas 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 had not been bothering me.
 My current complaints ALREADY existed and were worsened.

My most recent prior similar symptoms (if applicable) occurred____

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.

months ago / years ago **OR on** Date: ____/____/____

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