## **Patient Basic Information**

Personal Information:						
Last Name:	First Name:	Mid. Init.:				
Address:	City, State, Zip:	City, State, Zip:				
Home Phone:	Work P	Phone:		Social Security No.:		
Date of Birth:		Date of Injury/O	nset:			
Dominant Hand:	ht	□ Left	□ Both			
Insurance Information: Policy Holder (if different than patient): Policy No.:						
Special Note: If your injury involutions spaces below to fully describe you					use the	
Description of Accident/ Enter a full description of the accident, in			w.			
ь.			4			
2. Your condition during as Enter the details of your condition during		-		t		
				1		

## **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 Good  Who hit who/what?  You hit other vehicle  Other vehicle hit you  You hit(object)		Road conditions at time of a  Icy Wet Sand  Point of impact Head-On Read-End	accident  y □ Dark □ Clean and dry  □ Left Front □ Right Front □ Left Rear □ Right Rear				
7. Body Position, etc.								
Did you see the accident coming:  Ves No Were you braced for the impact? Did you have a seat belt on? Did you have a shoulder harness on?  Ves No Yes No Yes No Yes No Yes No Yes No Did you have a shoulder harness on?  Ves No Yes No No Did passenger side airbags deploy? Yes No No B. 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:			10. After the accident:					
Did your body strike the inside of If yes, describe:  Did you lose consciousness durin If yes, for how long?  Your vehicle's estimated damage'  Damage to their vehicle:  Did police show up at t Was an accident report	ng the injury? Yes \( \text{No} \) No  ?  Mild \( \text{Moderate} \) Moderate \( \text{Total} \) Tota the scene? Yes \( \text{Ves} \( \text{No} \)	- - - led	□ Headache □ Dizzine □ Neck pain □ Nausea □ Neck stiffnes □ Confusi □ Fainting □ Fatigue □ Ringing in ears □ Tension □ Loss of smell □ Irritability	Low back pain  Cold feet On  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 ☐ N Body parts X-rayed? What lab work? The X-rays revealed:	ospital ER Private Doctor  Ambulance Police  Was lab work done? Yes	-	Fill in any other doctor(s) s  1. Dr.  Specialty:  Types of treatments received: How many treatments receive Did treatments benefit you?	d? Currently treating? Yes \( \textstyle \text{No} \) Yes \( \textstyle \text{No} \) / First visit date://				
Medications:	lœ Otner:		d? Currently treating: Yes \( \simeq \) No					

Description	1 of Sy	mptom	<b>S</b> (D	escribe your symptoms in the sections below, in the order of severity, if p	ossible.)	
I. First Currer	nt Sympt	om: (Plea	se check	off the boxes below to describe your first symptom. Describe only ON	IE sympto	om per Section
1. Check only of	ne body l	ocation b	elow_	2. Types of pain		types of pain:
Headaches	L	R 🗖	В	□ Dull □ Sharp □ Aching □ Cutting		
	ront of He		1	☐ Throbbing ☐ Burning ☐ Numbing ☐ Tingling ☐ Crampin	q	
	op of Head			□ Spasm □ Stinging □ Shooting □ Pounding □ Constrict		
	Back of Hea			3. Pain Frequency 6. Actions affecting		in
Jaw		R □ R □	B □ B □		Brings On A	
□Eye □Neck	1 0	R	В	□ 1/2 to 3/4 of awake time □ Most all the time □ In the A.M.		
Upper Back	10	R 🖸	В	☐ In the P.M.		
☐ Mid Back	10	R	В	4. Pain Intensity (How it affects your daily activities)   Bending forward		
LowBack	נֿם	R 🗆	В	☐ Doesn't affect ☐ Somewhat affects ☐ Bending back		
Chest	L O	R 🗆	В	☐ Seriously affects ☐ Prevents activities ☐ Bending left		000000000
Abdomen	L	R 🗆	В□	5. Does this pain radiate into other body parts?		
Ribs	L 🔲	R 🔲	В	- I Wisting left		
Buttocks	L	R 🔲	В	Head I I I I I I I I I I I I I I I I I I I		
Shoulder	L 🛄	R 🛄	В 🔲	Neck C Coughing		
☐ Upper Arm	L 🛄	R 🔲	В 🔲	U Shoulder U U D Stanining	ä	<u> </u>
Forearm	L	R 🔲	В	UARM U U Dotdi	ă	<u> </u>
Hand		R 🔲	В	Hand U U D Sitting	ā	
Hip	L 0	R □ R □	В 🔲 В 🔲	U Hip U U I I I ifting		ā ā
□ Leg □ Foot		R	ВО	Leq Lostona		
Other locations		R L	b <b>u</b>	Foot Other Actions:	_ □	
Other locations	·			Other locations of radiation:		
II. Second Cu				(Please check off the boxes below to describe your next symptom).		
1. Check only o				2. Types of pain	Other	types of pain:
Headaches	L ☐ Front of He	R 🔲	В	☐ Dull ☐ Sharp ☐ Aching ☐ Cutting _		
	Top of Hea			☐ Throbbing ☐ Burning ☐ Numbing ☐ Tingling ☐ Crampin		
	Back of He			□ Spasm □ Stinging □ Shooting □ Pounding □ Constrict		
Jaw		R □	в□	3. Pain Frequency  6. Actions affecting		
□Eye		R 🔲	В	☐ 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 ☐ In the A.M.	snngs On A	Aggravates Relieves
□Neck		R 🔲	В	In the P.M.	ă	<u> </u>
☐ Upper Back	L 🛄	R 🔲	В 🛄	4. Pain Intensity (How it affects your daily activites) Bending forward		ă ă
☐ Mid Back		R 🔲	В	□ Doesn't affect □ Somewhat affects □ Bending back		<u> </u>
LowBack	LO	R 🔲	В	☐ Seriously affects ☐ Prevents activities ☐ Bending left		
Chest		R □ R □	ВП	Bending right		
□ Abdomen □ Ribs		R 🔲	В	5. Does this pain radiate into other body parts? Twisting left		
Buttocks		R	В	D Hood D D I Wisting right		
Shoulder	נ ם	R	В			
UpperArm	ī o	R 🗆	в	□ Shoulder □ □ □ □ Sneezing		
Forearm		R 🔲	В	O Straining O Standing		
□Hand	L	R 🔲	в 🔲	Hand Granting		
□Hip	L 🔲	R 🔲	В	□ Hip □ □ □ □ Sitting □ Lifting		5 5
Leg	L 🔲	R 🔲	В	lea l lea	_	
Foot	L 🔲	R 🚨	В		_ 0	
Other locations	š :			Other locations of radiation:		
III. Third Curr				Please check off the boxes below to describe your 3rd symptom).		
1. Check only o			elow B 🗖	2. Types of pain	Other	types of pain:
Headaches	L	R 🔲	RII	☐ Dull ☐ Sharp ☐ Aching ☐ Cutting		
	rant of Ha			a built a briary a cutting		
	ront of Head	ad	5 -	☐ Throbbing ☐ Burning ☐ Numbing ☐ Tingling ☐ Cramping		
דם	op of Head	ad 1	5 -	□ Throbbing □ Burning □ Numbing □ Tingling □ Crampin □ Spasm □ Stinging □ Shooting □ Pounding □ Constrict	ting	
דם		ad 1	в	□ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constrict □ Spain Frequency □ Actions affecting □ Constrict □ Actions affecting □ Cramping □ Constrict □ Constri	ting ng this pa	
□T □B	op of Head Back of Head L 🔲	ad d ad R 🔲 R 🔘	В 🔲 В 🔲	□ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constrict □ Spain Frequency □ Up to 1/4 of awake time □ 1/4 to 1/2 of time □ 6. Actions affecting □ Cramping □	ng this pa	Aggravates Relieves
□T □B □Jaw □Eye □Neck	op of Head Back of Head L 🔲 L 🔲	ad I ad R D R D	В <b>П</b> В <b>П</b>	□ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constrict  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 □ In the A.M.	ng this pa	Aggravates Relieves
□T □B □Jaw □Eye	op of Head Back of Head L D L D L D	ad ad R 🔲 R 🔲 R 🔲	B	□ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constrict  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 □ In the A.M. □ In the P.M.	ng this pa	Aggravates Relieves
□Taw □Eye □Neck □Upper Back □Mid Back	op of Head Back of Head L D L D L D L D	ad ad R C R C R C R C R C R C R C R C R C R C	B	□ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constrict  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 □ In the A.M. □ In the P.M.  4. Pain Intensity (How it affects your daily activites) □ Bending forward	ng this pa	Aggravates Relieves
□Jaw □Eye □Neck □Upper Back □Mid Back □LowBack	Top of Head Back of Head L Q L Q L Q L Q L Q	ad I I I I I I I I I I I I I I I I I I I	B B B B B B B	□ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constrict  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 □ In the A.M. □ In the P.M. □ In the P.M. □ Doesn't affect □ Somewhat affects □ Bending forward □ Bending back	ting  ng this pa Brings On A	Aggravates Relieves
Jaw Jeye Neck Upper Back Mid Back LowBack	Top of Head Back of Head L CO L CO L CO L CO L CO L CO L CO L CO	add did add add R C C C R C R C C R C R C C R C	B B B B B B B B	□ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constrict  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 □ In the A.M. □ In the P.M. □ In the P.M. □ Doesn't affect □ Somewhat affects □ Bending forward □ Bending back □ Seriously affects □ Prevents activities □ Bending left	ting  ng this pa  Brings On A	Aggravates Relieves
□ Jaw □ Eye □ Neck □ Upper Back □ Mid Back □ LowBack □ Chest □ Abdomen	Top of Head Back of Head L Q L Q L Q L Q L Q L Q L Q	ad d d R C C C C C C C C C C C C C C C C C C C	B B B B B B B B	□ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constrict  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 □ In the A.M. □ In the P.M. □ In the P.M. □ Bending forward □ Bending forward □ Seriously affects □ Prevents activities □ Bending left □ Bending left □ Bending right □ Bending right	ing this pa	Aggravates Relieves
Jaw Eye Neck Upper Back Mid Back LowBack Chest Abdomen Ribs	Top of Head Back of Head L Q L Q L Q L Q L Q L Q L Q L Q	ad H ad R R R R R R R R R R R R R R R R R R	B B B B B B B B B B B B B B B B B B B	□ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constrict  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 □ In the A.M. □ In the P.M. □ Bending forward □ Doesn't affect □ Somewhat affects □ Bending forward □ Bending back □ Seriously affects □ Prevents activities □ Bending left □ Bending right □ Twisting left □ Twisting left □ Twisting left	ing this pa	Aggravates Relieves
Jaw Eye Neck Upper Back Mid Back LowBack Chest Abdomen Ribs Buttocks	Top of Head Back of Head L Q L Q L Q L Q L Q L Q L Q L Q	ad	B B B B B B B B B B	□ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constrict  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 □ In the A.M. □ In the P.M. □ Bending forward □ Seriously affects □ Somewhat affects □ Seriously affects □ Prevents activities □ Bending left □ Bending right □ Head □ □ □ □ □ Twisting left □ Twisting left □ Twisting right	ng this pa	Aggravates Relieves
Jaw Eye Neck Upper Back Mid Back LowBack Chest Abdomen Ribs Buttocks Shoulder	Top of Head Back of Head L Q L Q L Q L Q L Q L Q L Q L Q L Q	ad	00000000000000000000000000000000000000	□ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constrict  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 □ In the A.M. □ In the P.M. □ In the P.M. □ In the P.M. □ Seriously affects □ Prevents activities □ Bending forward □ Seriously affects □ Prevents activities □ Bending left □ Bending right □ Twisting left □ Twisting left □ Twisting right □ Neck □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	ing this pa	Aggravates Relieves
Jaw Eye Neck Upper Back Mid Back LowBack Chest Abdomen Ribs Buttocks Shoulder Upper Arm	Top of Head Back of Head L Q L Q L Q L Q L Q L Q L Q L Q L Q L Q	ad	00000000000000	□ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constrict  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 □ In the A.M. □ In the P.M. □ In the P.M. □ Bending forward □ Somewhat affects □ Somewhat affects □ Bending forward □ Seriously affects □ Prevents activities □ Bending left □ Bending right □ Twisting left □ Twisting right □ Neck □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	ing this pa	Aggravates Relieves
Jaw Seye Neck Upper Back Mid Back Chest Abdomen Ribs Buttocks Shoulder Upper Arm Forearm	Top of Head Back of Head L Q L Q L Q L Q L Q L Q L Q L Q L Q L Q	ad 1	0000000000000	□ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constrict  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 □ In the A.M. □ In the P.M.  4. Pain Intensity (How it affects your daily activites) □ Doesn't affect □ Somewhat affects □ Bending forward □ Bending back □ Seriously affects □ Prevents activities □ Bending left □ Bending left □ Twisting left □ Twisting right □ Twisting right □ Coughing □ Sneezing □ Straining □ Straining □ Straining	ing this pa	Aggravates Relieves
Jaw Eye Neck Upper Back Mid Back LowBack Chest Abdomen Ribs Buttocks Shoulder Upper Arm	Top of Head Back of Head L Q L Q L Q L Q L Q L Q L Q L Q L Q L Q	ad	00000000000000	□ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constrict □ 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 □ In the A.M. □ In the P.M. □ Bending forward □ Doesn't affect □ Somewhat affects □ Bending forward □ Bending back □ Bending back □ Bending back □ Bending left □ Bending right □ Twisting left □ Twisting left □ Twisting left □ Twisting left □ Coughing □ Shoulder □ □ □ □ □ □ □ □ Straining □ Straining □ Standing □ Sitting	ing this pa	Aggravates Relieves
Jaw Jaw Seye Neck Upper Back Mid Back LowBack Chest Abdomen Ribs Buttocks Shoulder Upper Arm Forearm Hand	Top of Head Back of Head L Q L Q L Q L Q L Q L Q L Q L Q L Q L Q	ad	00000000000000	□ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constrict  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 □ In the A.M. □ In the P.M. □ In the P.M. □ Bending forward □ Seriously affects □ Prevents activities □ Bending left □ Bending left □ Head □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	ing this pa	Aggravates Relieves
Jaw Jaw Seye Neck Upper Back Mid Back LowBack Chest Abdomen Ribs Buttocks Shoulder Upper Arm Forearm Hand Hip	Top of Head Back of Head L Q L Q L Q L Q L Q L Q L Q L Q L Q L Q	ad	00000000000000000000000000000000000000	□ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constrict □ 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 □ In the A.M. □ In the P.M. □ Bending forward □ Doesn't affect □ Somewhat affects □ Bending forward □ Bending back □ Bending back □ Bending back □ Bending left □ Bending right □ Twisting left □ Twisting left □ Twisting left □ Twisting left □ Coughing □ Shoulder □ □ □ □ □ □ □ □ Straining □ Straining □ Standing □ Sitting	ing this pa	Aggravates Relieves

**Description of Symptoms** 

Description of Syn	nptoms	(Describe your	symptoms	in the section	s belov	v, in the order of sever	ity, if p	ossible	÷.)
IV. Fourth Symptom:	(Please check			e your 4th syr	nptom.	Describe only ONE s			
1. Check only one body locati		2. Types of pair					Other	types o	of pain:
☐ Front of Head		Dull C		Aching	Cu				
☐ Top of Head				☐ Numbing☐ Shooting	☐ Tin	gling			
☐ Back of Head ☐ Uaw L ☐ R 5	□ в□	3. Pain Frequen		■ Shooting		6. Actions affecting		pain	
□Jaw L □ R □   □Eye L □ R □		Up to 1/4 of awa	ake time			Bring			Relieves
Neck L R		☐ 1/2 to 3/4 of aw	ake time 🚨	Most all the tir	me	In the A.M.			
□UpperBack L □ R		4. Pain Intensity	(Llauvit affa a	45 d = ib	4114	☐ In the P.M.☐ Bending forward			
☐Mid Back L☐ R I		Doesn't affect		newhat affects		Bending back	ă		
□LowBack L □ R □ Chest L □ R □		☐ Seriously affect	attento.	vents activities		Bending left			
Abdomen L R		5. Does this pain	radiate into	other hody par	ts?	Bending right			
□Ribs L□ R			_eft Rig			<ul><li>☐ Twisting left</li><li>☐ Twisting right</li></ul>			
□ Buttocks L □ R I		☐ Head				☐ Coughing		ă	ö
☐Shoulder L☐ RI		☐ Neck☐ Shoulder				☐ Sneezing			
□Forearm L □ R		Arm				Straining		00000	00000
☐ Hand L☐ R		Hand				☐ Standing ☐ Sitting			H
□Hip L□ R		☐ Hip				☐ Lifting	ă		ă
□Leg L□ RU □Foot L□ RU	о в о о в о	☐ Leg ☐ Foot				Other Actions:			
Other locations :		Other locations							
V. Fifth Current Symptom:					cribe	your 5th symptom).			
1. Check only one body locat	ion below	2. Types of pai		3 DCIOW to dct	or ibe	our our symptomy.	Other	types	of pain:
☐Headaches L ☐ R ☐Front of Head	□ в□	☐ Dull ☐	Sharp	☐ Aching	☐ Cu				
☐ Top of Head		☐ Throbbing ☐		□ Numbing	☐ Tir				
☐ Back of Head		Spasm 3. Pain Frequer		■ Shooting	U Po	unding Constricting  6. Actions affecting		nain	
□Jaw L□ R □Eye L□ R		Up to 1/4 of awa		1/4 to 1/2 of	time	Brings	On Ago	•	Relieves
□Eye L□ R □Neck L□ R		☐ 1/2 to 3/4 of aw	/ake time	Most all the ti	me	☐ In the A.M.			
□UpperBack L □ R	□ в □	4 Dain Internaite	/1.1=it =#==	-4 d - ib	-41-441	☐ In the P.M.☐ Bending forward			
☐Mid Back L☐ R		4. Pain Intensity □ Doesn't affect		mewhat affects		Bending back	ă		ă
□LowBack L □ R □Chest L □ R		☐ Seriously affect		events activities		Bending left			
□Abdomen L □ R		5. Does this pain	radiate into	other body par	ts?	Bending right			00000000
□Ribs L□ R			Left Rig	ght Both		☐ Twisting left☐ Twisting right	ä		ä
□ Buttocks L □ R □ Shoulder L □ R		☐ Head ☐ Neck				□ Coughing			
☐ Shoulder L ☐ R ☐ UpperArm L ☐ R		Shoulder				Sneezing			
□Forearm L □ R		Arm				☐ Straining ☐ Standing			H
☐Hand L☐ R		☐ Hand				Stationg	ä		ä
□Hip L □ R □Lea L □ R		☐ Hip ☐ Lea				Lifting	$\overline{\Box}$		
□Leg L □ R □Foot L □ R		☐ Foot				OtherActions:			
Other locations :		Other locations							
VI. Sixth Current Symptom	n: (F	Please check off th	ne boxes be	low to describ	e your	6th symptom).	THE REAL PROPERTY.		
1. Check only one body locati	on below	2. Types of pai	n	No.			Other	types	of pain:
☐Headaches L ☐ R ☐	ВО			Aching	☐ Cu				
Top of Head				<ul><li>□ Numbing</li><li>□ Shooting</li></ul>	☐ Tir	ngling			
☐ Back of Head		3. Pain Frequer		- Shooting	<b>L</b> F 0	6. Actions affectin		nain	
□ Jaw L□ R [ □ Eye L□ R [		Up to 1/4 of aw	ake time				On Age		Relieves
□Neck L□ R	□ в□	□ 1/2 to 3/4 of av	vake time	Most all the ti	me	☐ In the A.M.			
Upper Back L R	В	4. Pain Intensity	(How it affect	rts vour daily a	ctivites	☐ In the P.M.☐ Bending forward			
☐ Mid Back L☐ R I		Doesn't affect		mewhat affect		Bending back	ä	ä	ä
Chest L R		☐ Seriously affect		events activities		☐ Bending left			
□ Abdomen L □ R	в 🔾	5. Does this pain	radiate into	other body par	ts?	Bending right			
□Ribs L□ R				ght Both		☐ Twisting left			
Buttocks L R		Head				☐ Twisting right ☐ Coughing		ä	ä
☐Shoulder L☐ R ☐		☐ Neck☐ Shoulder				☐ Sneezing		00000	$\overline{\Box}$
□Forearm L □ R I	□ в□	Arm				☐ Straining			
☐ Hand L☐ R	□ в□	☐ Hand				Standing			
□Hip L□ R!		Hip				☐ Sitting☐ Lifting			0000000000
□Leg L□ RI □Foot L□ RI		Leg Foot				Other Actions:			
Other locations :		Other location							

Description of Symptoms	(Describe your symptoms in the sections below, in	the order of severity, if possible.)
	off the boxes below to describe your 7th symptom	. Describe only ONE symptom per Section )
1. Check only one body location below  Headaches L R B B	2. Types of pain	Other types of pain:
□ Front of Head	□ Dull □ Sharp □ Aching □ Cu	
☐ Top of Head	☐ Throbbing ☐ Burning ☐ Numbing ☐ Till ☐ Spasm ☐ Stinging ☐ Shooting ☐ Po	ngling Crampingunding Constricting
□ Back of Head □ Daw L□ R□ B□	3. Pain Frequency	6. Actions affecting this pain
□Jaw L □ R □ B □   □Eye L □ R □ B □	Up to 1/4 of awake time 1/4 to 1/2 of time	Brings On Aggravates Relieves
Neck LOROBO	☐ 1/2 to 3/4 of awake time ☐ Most all the time	☐ In the A.M. ☐ ☐
□UpperBack L □ R □ B □	4 Painted and the state of the	☐ In the P.M. ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
☐Mid Back L☐ R☐ B☐	4. Pain Intensity (How it affects your daily activites)  ☐ Doesn't affect ☐ Somewhat affects	Bending back
□LowBack L□ R□ B□ □Chest L□ R□ B□	☐ Seriously affects ☐ Prevents activities	☐ Bending left ☐ ☐ ☐
□Abdomen L □ R □ B □	5. Does this pain radiate into other body parts?	Bending right
□Ribs L□ R□ B□	Left Right Both	☐ Twisting left ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
□Buttocks L□ R□ B□	Head	☐ Twisting left ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
☐Shoulder L ☐ R ☐ B ☐ ☐ ☐UpperArm L ☐ R ☐ B ☐	Neck	□ Sneezing □ □ □
□Forearm L□ R□ B□	Shoulder	Straining
□Hand L□ R□ B□	☐ Hand ☐ ☐ ☐	Standing
Hip L R B	□ Hip □ □	☐ Sitting ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
□Leg L□ R□ B□ □Foot L□ R□ B□	Deg D D	Other Actions:
Other locations:	Other locations of radiation:	
VIII. Eighth Current Symptom:		
1. Check only one body location below	(Please check off the boxes below to describe 2. Types of pain	Other types of pain:
□Headaches L □ R □ B □	□ Dull □ Sharp □ Aching □ Co	
☐ Front of Head	☐ Throbbing ☐ Burning ☐ Numbing ☐ Ti	ngling
☐ Top of Head ☐ Back of Head		unding Constricting
□Jaw L□ R□ B□	3. Pain Frequency Up to 1/4 of awake time 1/4 to 1/2 of time	6. Actions affecting this pain  Brings On Aggravates Relieves
DEye L R B	□ 1/2 to 3/4 of awake time □ Most all the time	☐ In the A.M.
□Neck L□ R□ B□ □UpperBack L□ R□ B□		☐ In the P.M. ☐ ☐ ☐
☐Mid Back L☐ R☐ B☐	4. Pain Intensity (How it affects your daily activites	
□LowBack L □ R □ B □	☐ Doesn't affect ☐ Somewhat affects ☐ Prevents activities	☐ Bending back ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Chest L R B		☐ Bending right ☐ ☐ ☐
□Abdomen L□ R□ B□ □Ribs L□ R□ B□	5. Does this pain radiate into other body parts?  Left Right Both	
Buttocks L R B B	Head D D	☐ Twisting right ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
☐Shoulder L ☐ R ☐ B ☐	□ Neck □ □ □	Coughing
UpperArm L R B B	Shoulder	□ Straining □ □ □
☐Forearm L☐ R☐ B☐ ☐Hand L☐ R☐ B☐	Arm	☐ Standing ☐ ☐ ☐
OHip LO RO BO	Hip D	
□Leg L□ R□ B□	Leg -	Lifting
□Foot L□ R□ B□		
Other locations :	Other locations of radiation:	
IX. Ninth Current Symptom:  1. Check only one body location below	Please check off the boxes below to describe your 2. Types of pain	
□Headaches L □ R □ B □	Dull Sharp Aching C	Other types of pain:
☐ Front of Head		ngling
☐ Top of Head☐ Back of Head☐		unding Constricting
QJaw L R B B	3. Pain Frequency	6. Actions affecting this 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	Brings On Aggravates Relieves
□Neck L□ R□ B□ □UpperBack L□ R□ B□	172 to 374 of avvake time 1 wost all the time	Calin the A.M. Calin the P.M. Calin the P.M. Calin the P.M. Calin Cali
□UpperBack L□ R□ B□ □Mid Back L□ R□ B□	4. Pain Intensity (How it affects your daily activites	☐ Bending forward ☐ ☐ ☐
□LowBack L □ R □ B □	Doesn't affect Somewhat affects	Bending back
☐Chest L☐ R☐ B☐	☐ Seriously affects ☐ Prevents activities	Bending left
□ Abdomen L □ R □ B □ □ Ribs L □ R □ B □	5. Does this pain radiate into other body parts?	Bending right
□Ribs L□ R□ B□ □Buttocks L□ R□ B□	Left Right Both	☐ Twisting right ☐ ☐ ☐
□Shoulder L□ R□ B□	Neck O O	Coughing D
□UpperArm L □ R □ B □	☐ Shoulder ☐ ☐ ☐	Sneezing
□Forearm L□ R□ B□ □Hand L□ R□ B□		Straining
□Hand L□ R□ B□ □Hip L□ R□ B□	Hand	☐ Sitting ☐ ☐
□Leg L□ R□ B□	Leg D D	Lifting
□Foot L□ R□ B□		OtherActions:
Other locations :	Other locations of radiation:	

## **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 forward         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       Competitive Sports       Dating         Golfing       Roller Skating       Hobbies       Dining out
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 Using a keyboard 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  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 Name	Date
Fill Out If You Have Been in a Job Related Injury	
Date and time of accident: a.m. p.m.  Was your accident directly related to your work? Yes No  Briefly describe the events that occurred just before and during your accident:	
Give the address where the accident occurred: (if other than employer's address)	
Was anyone else present during your accident? ☐ Yes ☐ No Did you report your accident to your employer? ☐ Yes ☐ No What recommendations did your employer make just after your accident?	
Has this type of accident happened to you before? ☐ Yes ☐ No  To the best of your knowledge, has this accident occurred in your workplace before? ☐ Yes ☐ No  In general:  ☐ Yes ☐ No	
Is your job mentally stressful?  Is your workplace noisy?  Have you changed jobs in the last year?  Yes □ No	
After Injury	
Did accident render you unconscious? ☐ Yes ☐ No  If yes, for how long?  Please describe how you felt immediately after the accident:	
Have you gone to a hospital or seen any other Doctor? ☐ Yes ☐ No  When did you go? ☐ Just after accident ☐ The next day ☐ 2 days plus  How did you get there? ☐ Ambulance ☐ Private transportation  Name of hospital and/ or attending doctor:	
Was he/she a:   D.C.   M.D   D.O   D.D.S  Describe any treatment you received:  Were X-Rays taken?   Yes   No  Was medication prescribed?   Yes   No	
Have you been able to work since this injury? ☐ Yes ☐ No  Are your work activities restricted as a result of this injury? ☐ Yes ☐ No	,

Indicate the symptoms that are a result of this accident:										
	Dizziness	☐ Difficulty Sleeping	Sleeping				Nausea			
	Memory loss	☐ Irritability	☐ Arms/ shoulder pain				Back pain			
	Headache(s)	☐ Fatigue		Numb ha	nds/		Lower back pain			
	Blurred vision	☐ Tension	fin	gers			Back stiffness			
	Buzzing in ear	☐ Neck pain		Chest pa	in		Leg pain			
	Ears ringing	□ Neck stiff		Shortnes	s of breath		Numb feet/ toes			
				Stomach	upset					
	Other									
		ing worse?  Yes					and goes			
Indi	cate your degree	of comfort while perfor								
			mfor	table (	Uncomfortabl		Painful			
Lyir	ng on back									
-										
-										
Stre	etching									
Lov	emaking									
Wai	lking									
Run	nning									
Spo	orts									
Wor	rking									
Lifti	ng									
Ben	nding									
Kne	eeling									
Pull	ling									
Rea	aching									
Hav	ve you retained ar	n attorney:   Yes [	□ No	)						
	Her phone #:									
				-				-		

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

Recovery	
How many hours are in your normal workday?	
Please indicate on your daily job duties and any activities, which you are occasionally asked to perform.	
☐ Standing ☐ Driving ☐ Operating equipment	
☐ Sitting ☐ Twisting ☐ Work with arms above	
☐ Walking ☐ Crawling head	
☐ Lifting ☐ Bending ☐ Typing	
□ Stooping	
□ Other	
What positions can you work in with minimum physical effort and for how long?	
	N/A
Prior to the injury were you capable of working on an equal basis with others your age?   Yes   No   N/A	
Do you work with others who can help you with any heavy lifting? ☐ Yes ☐ No ☐ N/A	
While in recovery, is there any light duty work you could request? ☐ Yes ☐ No ☐ N/A	
<ul> <li>We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, nunderstanding between provider and patient.</li> </ul>	nutual
o Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been	n
made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and other expenses incurred in collecting your account.	any
<ul> <li>I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.</li> </ul>	
<ul> <li>I understand the above information and guarantee this form was completed correctly to the best of my knowledge a understand it is my responsibility to inform this office of any changes to the information I have provided.</li> </ul>	nd
Signature Date//	
□ Adult patient □ Parent or Guardian □ Spouse	

Patient Name

Date \_\_\_\_\_