NAME_____AGE_____SEX_____DATE_____

Referred by:
___ friend
___ relative
___ another patient
___ physician
___ lawyer
___ insurance company
___ other

Name_____

How were you hurt?
___ Don't Know
___ Injury at Home
___ Injury at Work
___ Motor vehicle accident
___ It just started
___ Other

check all that apply

DESCRIBE HOW IT OCCURRED.

Fill out for work related injuries only

Date of Injury _____
Employer _____
How employed? _____
Length of Employment _____
Did you report injury? _____
To whom? _____
Did you fill out accident report? _____

Fill out for motor vehicle accidents only

Date of Accident _____
Time of Accident _____
Location _____
Did Police come _____
Who was cited as causing the accident _____
Were you seatbelted _____
Was accident report filed _____
Speed at which accident occurred:
_____mph

List all Doctors, emergency rooms or clinics that have treated you for this injury or illness.

Check type of accident
___ rear end
___ head on
___ side to side
___ front to side
___ front to rear

Where were you seated?
___ driver ___ front seat passenger
___ rear seat passenger

Check all treatments or medications that have been tried to help you.
___ PT
___ Massage
___ Heat
___ Diathermy
___ Ultrasound
___ Bed Rest
___ Adjustments
___ Chiropractic
___ Traction
___ Pain Pills
___ Muscle Relaxors
___ Arthritis Pills
___ Cortisone Shots
___ Tranquilizers
___ Nerve Pills

List Allergies to medications

List all medications you are currently taking

Do you have?
___ High Blood Pressure
___ Heart Trouble
___ Diabetes
___ Ulcers
___ Free Bleeding
___ Other

List any surgeries you have had.

Name _____

MAIN COMPLAINT

__ Headache
__ Neck Pain
__ Shoulder Pain
__ Arm Pain
__ Upper Back Pain
__ Low Back Pain
__ Hip Pain
__ Leg Pain
__ Other describe below

_____
_____

Check all that apply

Describe pain

__ sharp
__ dull
__ aching
__ throbbing
__ electric
__ knife like
__ pressure
__ shooting
__ like fire
__ burning

Check all that apply

Pain spreads to:

__ R shoulder
__ R arm
__ R hand
__ R fingers
__ R hip
__ R groin
__ R thigh
__ R calf
__ R ankle
__ R foot
__ R toes

__ L shoulder
__ L arm
__ L hand
__ L fingers
__ L hip
__ L groin
__ L thigh
__ L calf
__ L ankle
__ L foot
__ L toes

Which side is worse?

__ Right
__ Left

Check all that apply

Date pain began:

_____/_____
month day year

Pain began:

__ slowly
__ immediately
__ suddenly
__ at time of injury
__ at work
__ the next morning
__ that night

Pain is getting:

__ worse
__ better
__ staying the same

Check all that apply

Pain is:

__ continuous
__ intermittant
__ comes & goes
__ worse on arising
__ better on arising
__ worse as day goes on
__ better as day goes on
__ worse in evening
__ worse at night
__ better at night
__ constantly present

Check all that apply

Pain lasts:

__ seconds
__ a few minutes
__ half hour
__ hour
__ a few hours
__ several hours
__ day
__ several days
__ week
__ weeks
__ months
__ years
__ never goes away

Check all that apply

Pain is made worse by:

__ sitting
__ standing
__ walking
__ lying
__ riding in car
__ coughing
__ sneezing
__ bowel movement
__ bending
__ lying on back
__ getting up from sitting
__ activity
__ moving or turning neck
__ moving arm or shoulder

_____
_____

Check all that apply

Pain is better with:

__ rest
__ lying down
__ sitting down
__ pain pills
__ muscle relaxors
__ arthritis medication
__ walking
__ nothing helps
__ excercise

_____
_____
_____

list anything that helps

Check all that apply

Name _____

Do you have:

__ numbness
__ tingling
__ weakness
__ paralysis
__ difficulty urinating
__ loss of bowel movement
__ loss of urine
__ inability to have sex
__ inability to get an erection

Check areas that are numb

__ face
__ neck
__ shoulder
__ arm
__ hand
__ thumb
__ forefinger
__ middle finger
__ ring finger
__ little finger
__ all fingers
__ back
__ hip
__ thigh
__ groin
__ genitalia
__ calf
__ foreleg
__ foot
__ big toe
__ little toe
__ all toes

Which side is worse?

__ Right
__ Left

What areas have been weak or paralyzed?

__ arm
__ hand
__ leg
__ foot
__ finger
__ toe

Which side is worse?

__ Right
__ Left

Check those that apply

___ My back gets stuck when I bend forward
___ My back feels that it will give way when I bend forward
___ My pain stops me after I walk a certain distance
___ My legs get weak after I walk a ways
___ I limp when I walk
___ After walking, sitting helps my pain or weakness
___ It bothers me to work with my arms overhead
___ My leg may jump and go out from under me
___ I have fallen because my leg gave way
___ I can't open jars
___ I have trouble handling small objects
___ I have difficulty holding onto a cup of coffee
___ I have trouble handling skillets and pans

Check those that apply

___ I can live with the pain if I knew the cause
___ I deserve better treatment when I am in pain
___ I would commit to an extended health program if it would help
___ No one understands how bad the pain is
___ I can't sleep at night and wander around the house to find relief
___ Something Has got to be done
___ I can't take the pain any longer
___ The pain makes me irritable and I can't get along with my family
___ I am afraid of losing my job because of the pain
___ Tension and anxiety make the pain worse
___ I have been to many doctors and no one seems to help me
___ My employer has not been fair to me during this illness
___ I have an attorney to help me seek justice
___ I am not satisfied with my insurance company
___ Everything is going wrong with my life
___ My illness is causing marital difficulties

Name_____

In the boxes below check any problems you now have, or have ever had.

HEENT

___ Headache
___ Dizziness
___ Fainting, Syncope
___ Hearing Loss
___ Ringing in Ear
___ Hoarseness
___ Difficulty Swallowing
___ Visual Loss
___ Frequent Nose Bleeds
___ Sinus Trouble

LUNGS

___ Cough
___ Difficulty Breathing
___ Coughing up Blood
___ Wheezing
___ Chest Pain
___ Bronchitis
___ Pneumonia
___ TB
___ Night Sweats
___ Asthma

HEART

___ Palpitations
___ Murmur
___ Chest Pain
___ Irregular Heart Beat
___ Shortness of Breath
___ High Blood Pressure
___ Angina
___ Heart Attack
___ Ankle Swelling
___ Abnormal EKG

HABITS

___ Smoke Cigarettes
___ Alcohol Abuse
___ Drug Abuse

GASTROINTESTINAL

___ Loss of Appetite
___ Undesired Weight Loss
___ Frequent Indigestion
___ Frequent Nausea, Vomiting
___ Frequent Diarrhea
___ Frequent Constipation
___ Change of Bowel Habits
___ Bloating, Gas
___ Food Intolerance
___ Black Tarry Stool
___ Vomiting Blood
___ Ulcers
___ Irritable Bowel/Colon
___ Hemmorhoids
___ Rectal Fissure/Fistula
___ Hiatal Hernia
___ Frequent Heartburn
___ Yellow Jaundice
___ Gallbladder trouble
___ Hepatitis

GENITOURINARY

___ Painful Urination
___ Frequent Urination
___ Difficulty Starting
___ Urinating too Frequently at Night
___ Loss of Urine Unintentionally
___ Blood in Urine
___ Frequent Bladder Infections
___ Frequent Kidney Infections
___ Kidney/Bladder Stones
___ Venereal Disease

GYNECOLOGIC

___ Vaginal Discharge
___ Vaginal Bleeding between Periods
___ Painful Periods
___ Irregular Periods
___ Lump in Breast
_____ Number of Pregnancies
_____ Number of Children
_____ How Many Days between Periods
_____ How Many Days Does Period Last
_____ Date of Last Pap Smear
_____ Date of Last Mammogram

MENTAL

___ Disorientation
___ Loss of Consciousness
___ Memory Loss
___ Frequent Forgetting
___ Depression
___ Anxiety
___ Difficulty Speaking
___ Get Lost Frequently
___ Hallucination
___ Nervous Breakdown

NEUROMUSCULAR

___ Convulsions
___ Epilepsy
___ Seizures
___ Stroke
___ Paralysis
___ Head Injury
___ Tremor
___ Arthritis
___ Broken Bones
___ Painful Joints
___ Poor Coordination
___ Insomnia
___ Excess Drowsiness
___ Severe Muscle Cramps

FAMILY HISTORY

Has anyone in your family had:

___ Diabetes
___ Tuberculosis
___ Cancer
___ Stroke
___ Epilepsy, Convulsions
___ Insanity
___ Heart Disease
___ Muscle Disease
___ Nervous Disorder
___ Hypertension

list who below

_____

_____

SOCIAL HISTORY

Are you married?_____

Do you smoke _____ # of packs_____ for_____ years

Do you use other forms of tobacco?_____ Drug abuse?_____

Do you drink alcohol?_____ # of drinks weekly_____

FAMILY HISTORY

Mother: Living or Deceased _____ Age _____ Cause if deceased _____

Father: Living or Deceased _____ Age _____ Cause if deceased _____

Brother: Living or Deceased _____ Age _____ Cause if Deceased _____

Brother: Living or Deceased _____ Age _____ Cause if Deceased _____

Sister: Living or Deceased _____ Age _____ Cause if Deceased _____

Sister: Living or Deceased _____ Age _____ Cause if Deceased _____

Other: Living or Deceased _____ Age _____ Cause if Deceased _____

Have either of your parents or siblings had any of the following (Use M, F, B, S):

_____Heart Disease

_____High Blood Pressure

_____Mental Or Emotional Problems

_____Epilepsy or other Nervous System Problems

_____Kidney Disease

_____Muscle Disease

_____Stroke

_____Cancer