Patient Basic Information

Personal Information:

First Name:

Last Name:

Middle Initial:

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: Claim No:

Description of Accident/Injury/Onset
If this is an automobile accident, you can use the MVA Section.

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

Automobile Accident Description

Your Vehicle Type:
❍Car ❍S.U.V. ❍Van ❍Bus
❍Large Truck ❍Pickup Truck

Other Type:_____

Your Position in Vehicle
❍Driver ❍Front Passenger
❍ L.Rear Passenger ❍ R.Rear Passenger

Other Position:_____

Time/Speed/Damage
Time of Accident: Your Speed
Their Speed

Damage to your vehicle:
❍Mild ❍Moderate ❍Totaled

What was your vehicle doing at time of accident?
❍ Stopped at intersection ❍ Stopped in traffic ❍ Stopped at a light
❍ Making a right turn ❍ Making a left turn ❍ Parking
❍ Proceeding along ❍ Slowing down ❍ Accelerating

Other:_____

Details of Accident:

Visibility at the time:
❍ Good ❍ Fair ❍ Poor

Road Conditions at Time of Accident:
❍ Icy ❍ Wet ❍ Sandy
❍ Dark ❍ Clean & Dry

Point of Impact:
❍ Head-On ❍ Rear-End
❍ Left front ❍ Right front
❍ Left rear ❍ Right rear

Other:_____

Who hit who/what:
❍ You hit other vehicle
❍ Other vehicle hit you
You hit….(Type in object below)

Other:_____

Additional Accident Information:
In the case of a motor vehicle accident, write any additional info here.

During the Accident:

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
Did the driver's front air bag deploy?.. Yes ❑❑ No
Did passenger front air bags deploy? Yes ❑❑ No
Did the side air bags deploy?…… Yes ❑❑ No
Does your vehicle have headrests?… Yes ❑❑ No

Headrest Position?
❍ Even with top of head
❍ Even with bottom of head
❍ Even with middle of the neck

What was the direction of the head at the time of impact?
❍ Facing straight forward ❍ Turned to the right ❍ Turned to the left

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

Emergency Room?
Where did you go after the accident?
❍ Home ❍ Work
❍ Hospital ER ❍ Private doctor

How did you get there?
❍ Drove Self ❍ Ambulance
❍ Somebody Else ❍ Police

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:

After the Accident:
Check off the symptoms right after and a few days following the accident.

❑ Headache ❑ Loss of smell ❑ Tension ❑ Loss of taste ❑ Diarrhea
❑ Neck pain ❑ Dizziness ❑ Irritability ❑ Toe numbness ❑ Depression
❑ Neck stiffness ❑ Nausea ❑ Mid back pain ❑ Constipation ❑ Anxious
❑ Fainting ❑ Confusion ❑ Low back pain ❑ Cold hands ❑ Chest pain
❑ Ringing in ears ❑ Fatigue ❑ Nervousness ❑ Cold Feet
❑ Pain behind eyes ❑ Shortness of breath ❑ Sleeping problems

Others:

Doctor's Additional Data on This Patient
NOTE: This will be entered into the chart, but will not appear in Reports

Patient's Signature:_____ **Date:**_____

Historical Information

Prior Treatment Information

Prior Similar Symptoms:
- ❍ I have NOT had prior similar symptoms to current complaints.
- ❍ My current complaints DID exist before, but had been dormant.
- ❍ My current complaints ALREADY existed and were worsened.

Has your History Contributed to your 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 symptoms.

My Most Recent Prior Similar Symptoms (if applicable)

My most recent prior similar symptons occurred…

☐ ❍ Months ❍ Years…ago **OR** on (Date) ☐

Medical History Section:
Enter additional Medical Historical data here.

Surgical Historical Section:
Enter any Surgical Historical data here.

Treatment History 1:
Fill in any other doctor(s) seen prior to your first visit to this office.

2. Name: ☐ Specialty: ☐

First Visit Date ☐

Last Visit Date ☐

Types of Treatments Received: ☐

How many Tx's Received? ☐ Did Tx's help? Yes ❑❑ No X-rays done? Yes ❑❑ No

Currently Treating? Yes ❑❑ No

Medications History Section:
Enter any Medications Historical data here.

Occupational History Section:
Enter Occupational History, e.g. lost work, etc. Here.

Treatment History 2:
Fill in any other doctor(s) seen prior to your first visit to this office.

2. Name: ☐ Specialty: ☐

First Visit Date ☐

Last Visit Date ☐

Types of Treatments Received: ☐

How many Tx's Received? ☐ Did Tx's help? Yes ❑❑ No X-rays done? Yes ❑❑ No

Currently Treating? Yes ❑❑ No

Familial History Section:
Enter relevant Familial History here.

Social History Section:
Enter any relevant Social History here.

Treatment History 3:
Fill in any other doctor(s) seen prior to your first visit to this office.

1. Name: ☐ Specialty: ☐

First Visit Date ☐

Last Visit Date ☐

Types of Treatments Received: ☐

How many Tx's Received? ☐ Did Tx's help? Yes ❑❑ No X-rays done? Yes ❑❑ No

Currently Treating? Yes ❑❑ No

Additional Historical Information Section:
Summarize other treatments that were received here.

Prior Treatment Section:
Summarize past treatments received here.

Treatment History 4:
Fill in any other doctor(s) seen prior to your first visit to this office.

4. Name: ☐ Specialty: ☐

First Visit Date ☐

Last Visit Date ☐

Types of Treatments Received: ☐

How many Tx's Received? ☐ Did Tx's help? Yes ❑❑ No X-rays done? Yes ❑❑ No

Currently Treating? Yes ❑❑ No

Patient's Signature:_____ **Date:**_____

Current Complaints

1. Location of Pain:

- ❑ Headaches LO RO BO
  - ❍ Front of Head
  - ❍ Top and/or Sides
  - ❍ Back of Head
- ❑ Jaw…….. LO RO BO
- ❑ Eye…….. LO RO BO
- ❑ Neck…… LO RO BO
- ❑ Uppr. Back.. LO RO BO
- ❑ Mid Back…. LO RO BO
- ❑ Low Back…. LO RO BO
- ❑ Chest…… LO RO BO
- ❑ Abdomen…. LO RO BO
- ❑ Ribs…… LO RO BO
- ❑ Buttocks…. LO RO BO
- ❑ Shoulder….. LO RO BO
- ❑ Uppr. Arm… LO RO BO
- ❑ Foreman….. LO RO BO
- ❑ Hand…… LO RO BO
- ❑ Hip…… LO RO BO
- ❑ Leg…….. LO RO BO
- ❑ Foot…….. LO RO BO

Other Locations:

Types of Pain:

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

Other Types of Pain:

Does this Pain Radiate?

- ❑ Head…….LO RO BO
- ❑ Neck…… LO RO BO
- ❑ Shoulder…LO RO BO
- ❑ Arm…….LO RO BO
- ❑ Hand…… LO RO BO
- ❑ Hip…..… LO RO BO
- ❑ Leg…….. LO RO BO
- ❑ Foot…… LO RO BO

Other Locations:

Actions Affecting Pain

B=Brings on A=Aggravates
R=Relieves

	B	A	R
❑ In the A.M.	❑	❑	❑
❑ In the P.M.	❑	❑	❑
❑ Bending Fwd	❑	❑	❑
❑ Bending Back	❑	❑	❑
❑ Bending Left	❑	❑	❑
❑ Bending Rt.	❑	❑	❑
❑ Twisting Left	❑	❑	❑
❑ Twisting Rt.	❑	❑	❑
❑ Coughing	❑	❑	❑
❑ Sneezing	❑	❑	❑
❑ Straining	❑	❑	❑
❑ Standing	❑	❑	❑
❑ Sitting	❑	❑	❑
❑ Lifting	❑	❑	❑
Other Actions:			
	❑	❑	❑
	❑	❑	❑
	❑	❑	❑
	❑	❑	❑

Pain Frequency:

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

Pain Intensity:

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

Additional Data on above Symptom

2. Location of Pain:

- ❑ Headaches LO RO BO
  - ❍ Front of Head
  - ❍ Top and/or Sides
  - ❍ Back of Head
- ❑ Jaw…….. LO RO BO
- ❑ Eye…….. LO RO BO
- ❑ Neck…… LO RO BO
- ❑ Uppr. Back.. LO RO BO
- ❑ Mid Back…. LO RO BO
- ❑ Low Back…. LO RO BO
- ❑ Chest…… LO RO BO
- ❑ Abdomen…. LO RO BO
- ❑ Ribs…… LO RO BO
- ❑ Buttocks…. LO RO BO
- ❑ Shoulder….. LO RO BO
- ❑ Uppr. Arm… LO RO BO
- ❑ Foreman….. LO RO BO
- ❑ Hand…… LO RO BO
- ❑ Hip…… LO RO BO
- ❑ Leg…….. LO RO BO
- ❑ Foot…… LO RO BO

Other Locations:

Types of Pain:

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

Other Types of Pain:

Does this Pain Radiate?

- ❑ Head……. LO RO BO
- ❑ Neck…… LO RO BO
- ❑ Shoulder…LO RO BO
- ❑ Arm…….LO RO BO
- ❑ Hand…… LO RO BO
- ❑ Hip…..… LO RO BO
- ❑ Leg…….. LO RO BO
- ❑ Foot…… LO RO BO

Other Locations:

Actions Affecting Pain

B=Brings on A=Aggravates
R=Relieves

	B	A	R
❑ In the A.M.	❑	❑	❑
❑ In the P.M.	❑	❑	❑
❑ Bending Fwd	❑	❑	❑
❑ Bending Back	❑	❑	❑
❑ Bending Left	❑	❑	❑
❑ Bending Rt.	❑	❑	❑
❑ Twisting Left	❑	❑	❑
❑ Twisting Rt.	❑	❑	❑
❑ Coughing	❑	❑	❑
❑ Sneezing	❑	❑	❑
❑ Straining	❑	❑	❑
❑ Standing	❑	❑	❑
❑ Sitting	❑	❑	❑
❑ Lifting	❑	❑	❑
Other Actions:			
	❑	❑	❑
	❑	❑	❑
	❑	❑	❑
	❑	❑	❑

Pain Frequency:

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

Pain Intensity:

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

Additional Data on above Symptom

3. Location of Pain:

- ❑ Headaches LO RO BO
  - ❍ Front of Head
  - ❍ Top and/or Sides
  - ❍ Back of Head
- ❑ Jaw…….. LO RO BO
- ❑ Eye…….. LO RO BO
- ❑ Neck…… LO RO BO
- ❑ Uppr. Back.. LO RO BO
- ❑ Mid Back…. LO RO BO
- ❑ Low Back…. LO RO BO
- ❑ Chest…… LO RO BO
- ❑ Abdomen…. LO RO BO
- ❑ Ribs…… LO RO BO
- ❑ Buttocks…. LO RO BO
- ❑ Shoulder….. LO RO BO
- ❑ Uppr. Arm… LO RO BO
- ❑ Foreman….. LO RO BO
- ❑ Hand…… LO RO BO
- ❑ Hip…… LO RO BO
- ❑ Leg…….. LO RO BO
- ❑ Foot…… LO RO BO

Other Locations:

Types of Pain:

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

Other Types of Pain:

Does this Pain Radiate?

- ❑ Head……. LO RO BO
- ❑ Neck…… LO RO BO
- ❑ Shoulder…LO RO BO
- ❑ Arm…….LO RO BO
- ❑ Hand…… LO RO BO
- ❑ Hip…..… LO RO BO
- ❑ Leg…….. LO RO BO
- ❑ Foot…… LO RO BO

Other Locations:

Actions Affecting Pain

B=Brings on A=Aggravates
R=Relieves

	B	A	R
❑ In the A.M.	❑	❑	❑
❑ In the P.M.	❑	❑	❑
❑ Bending Fwd	❑	❑	❑
❑ Bending Back	❑	❑	❑
❑ Bending Left	❑	❑	❑
❑ Bending Rt.	❑	❑	❑
❑ Twisting Left	❑	❑	❑
❑ Twisting Rt.	❑	❑	❑
❑ Coughing	❑	❑	❑
❑ Sneezing	❑	❑	❑
❑ Straining	❑	❑	❑
❑ Standing	❑	❑	❑
❑ Sitting	❑	❑	❑
❑ Lifting	❑	❑	❑
Other Actions:			
	❑	❑	❑
	❑	❑	❑
	❑	❑	❑
	❑	❑	❑

Pain Frequency:

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

Pain Intensity:

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

Additional Data on above Symptom

Patient's Signature:_____ **Date:**_____

Activities of Daily Living

Activities of Daily Living Scale #1
Use the following 1 to 5 Scale to describe the difficulties below, down through Travelling.

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."

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..☐ As a passenger in a motor vehicle…☐ As a passenger on a train..☐ Driving for long periods of time…☐ As airplane passenger.☐

Activities of Daily Living Scale #2
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..☐ Touch..☐ Taste..☐ Sense of Smell.☐

Difficulties with Hand Functions:

Grasping…☐ Holding…☐ Pinching…☐ Percussive movements..☐ Sensory discrimination..☐

Difficulties with Sleep and Sexual Activity:

Being able to have a normal, restful nights sleep.....☐

Being able to participate in desired sexual activity…☐

Additional Activities of Daily Living Information:

Patient's Signature:_____ **Date:**_____