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: ❑Right ❑Left ❑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
❑Read-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

	L	R	B
❑Headaches	❑	❑	❑
❑Front of Head			
❑Top of Head			
❑Back of Head			
❑Jaw	❑	❑	❑
❑Eye	❑	❑	❑
❑Neck	❑	❑	❑
❑Upper Back	❑	❑	❑
❑Mid Back	❑	❑	❑
❑Low Back	❑	❑	❑
❑Chest	❑	❑	❑
❑Abdomen	❑	❑	❑
❑Ribs	❑	❑	❑
❑Buttocks	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Upper Arm	❑	❑	❑
❑Forearm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

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 activites)

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

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑Head	❑	❑	❑
❑Neck	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Arm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations of radiation:_____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑In the A.M.	❑	❑	❑
❑In the P.M.	❑	❑	❑
❑Bending forwrd.	❑	❑	❑
❑Bending back	❑	❑	❑
❑Bending left	❑	❑	❑
❑Bending right	❑	❑	❑
❑Twisting left	❑	❑	❑
❑Twisting right	❑	❑	❑
❑Coughing	❑	❑	❑
❑Sneezing	❑	❑	❑
❑Straining	❑	❑	❑
❑Standing	❑	❑	❑
❑Sitting	❑	❑	❑
❑Lifting	❑	❑	❑
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

	L	R	B
❑Headaches	❑	❑	❑
❑Front of Head			
❑Top of Head			
❑Back of Head			
❑Jaw	❑	❑	❑
❑Eye	❑	❑	❑
❑Neck	❑	❑	❑
❑Upper Back	❑	❑	❑
❑Mid Back	❑	❑	❑
❑Low Back	❑	❑	❑
❑Chest	❑	❑	❑
❑Abdomen	❑	❑	❑
❑Ribs	❑	❑	❑
❑Buttocks	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Upper Arm	❑	❑	❑
❑Forearm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

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 activites)

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

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑Head	❑	❑	❑
❑Neck	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Arm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations of radiation:_____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑In the A.M.	❑	❑	❑
❑In the P.M.	❑	❑	❑
❑Bending forwrd.	❑	❑	❑
❑Bending back	❑	❑	❑
❑Bending left	❑	❑	❑
❑Bending right	❑	❑	❑
❑Twisting left	❑	❑	❑
❑Twisting right	❑	❑	❑
❑Coughing	❑	❑	❑
❑Sneezing	❑	❑	❑
❑Straining	❑	❑	❑
❑Standing	❑	❑	❑
❑Sitting	❑	❑	❑
❑Lifting	❑	❑	❑
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

	L	R	B
❑Headaches	❑	❑	❑
❑Front of Head			
❑Top of Head			
❑Back of Head			
❑Jaw	❑	❑	❑
❑Eye	❑	❑	❑
❑Neck	❑	❑	❑
❑Upper Back	❑	❑	❑
❑Mid Back	❑	❑	❑
❑Low Back	❑	❑	❑
❑Chest	❑	❑	❑
❑Abdomen	❑	❑	❑
❑Ribs	❑	❑	❑
❑Buttocks	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Upper Arm	❑	❑	❑
❑Forearm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

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 activites)

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

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑Head	❑	❑	❑
❑Neck	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Arm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations of radiation:_____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑In the A.M.	❑	❑	❑
❑In the P.M.	❑	❑	❑
❑Bending forwrd.	❑	❑	❑
❑Bending back	❑	❑	❑
❑Bending left	❑	❑	❑
❑Bending right	❑	❑	❑
❑Twisting left	❑	❑	❑
❑Twisting right	❑	❑	❑
❑Coughing	❑	❑	❑
❑Sneezing	❑	❑	❑
❑Straining	❑	❑	❑
❑Standing	❑	❑	❑
❑Sitting	❑	❑	❑
❑Lifting	❑	❑	❑
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 hav 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 applicabl**e) occured____ ❑months ago / ❑years ago **OR on** Date:_____/_____/_____

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.

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

