

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: _____

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

Check type of accident _____ mph

- 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 any surgeries you have had.

List all medications you are currently taking

Do you have?

- High Blood Pressure
- Heart Trouble
- Diabetes
- Ulcers
- Free Bleeding
- Other

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
- exercise

list anything that helps

Check all that apply

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

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> face | <input type="checkbox"/> back |
| <input type="checkbox"/> neck | <input type="checkbox"/> hip |
| <input type="checkbox"/> shoulder | <input type="checkbox"/> thigh |
| <input type="checkbox"/> arm | <input type="checkbox"/> groin |
| <input type="checkbox"/> hand | <input type="checkbox"/> genitalia |
| <input type="checkbox"/> thumb | <input type="checkbox"/> calf |
| <input type="checkbox"/> forefinger | <input type="checkbox"/> foreleg |
| <input type="checkbox"/> middle finger | <input type="checkbox"/> foot |
| <input type="checkbox"/> ring finger | <input type="checkbox"/> big toe |
| <input type="checkbox"/> little finger | <input type="checkbox"/> little toe |
| <input type="checkbox"/> all fingers | <input type="checkbox"/> all toes |

What areas have been weak or paralyzed?

- arm
- hand
- leg
- foot
- finger
- toe

Which side is worse?

- Right
- Left

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

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
- Hemorrhoids
- 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

NEUROMUSCULAR

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

MENTAL

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

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

