ADVANCED BACK & NECK PAIN CENTER
F-54 Omega Drive
Newark, DE 19713
302-368-1300
302-368-1695
www.advancedback.com

SLIP/FALL INITIAL DOCTOR-NEW PATIENT INTERVIEW FORM

Patient: _____ Age: _____ Birth Date: _____

Time In: _____ Time Out: _____ Date of Accident: _____

Doctor: _____ Date Of Exam: _____

Sex: ☐ M ☐ F Marital Status: _____ Spouse Name: _____ # of Children: _____

Occupation: _____Years: _____ Employer: _____

Are you or have you missed time from work? ☐Yes ☐ No Type of Work: ☐ Office ☐ Clerical ☐ Light ☐ Moderate ☐ Heavy Labor

Describe the type of work performed: _____

Were you on-the-job when the accident occurred? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Whom? _____

Was anyone notified? ☐ Yes ☐ No Whom?_____

If yes, was a report made? ☐ Yes ☐ No

Accident Description: (How did the accident happen?) _____

_____

_____

What part of your body did you hit? Describe _____

Did you lose consciousness? ☐ Yes ☐ No If yes, for how long _____

Since the accident, tell me **ALL** symptoms or injuries you have experienced and specifically when each began: _____

_____

_____

Where did you go after accident? ☐ Hospital ☐ Urgent Care ☐ Family Provider ☐ Home ☐ Work ☐ Other_____

Emergency Room Treatment:

Were you seen in the ER: ☐ Yes ☐ No Which hospital: _____ Were taken by ambulance? ☐ Yes ☐ No

Date seen if not taken by ambulance _____

Was treatment given? ☐ Yes ☐ No If yes, X-rays: ☐ Yes ☐ If yes, which body parts x-rayed _____

Results of X-rays: _____ Lab work ☐ Yes ☐ No Results: _____

Cervical collar ☐Yes ☐No Ice ☐ Yes ☐ No Medication: ☐ Yes ☐ No If yes, name of Rx: _____

Other treatment: _____ Follow-up Instructions: _____ ☐ None

Work restriction ☐ Yes ☐ No If yes, describe_____

Dr. Initials: _____

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Patient: _____

Other Treatment Since Accident #1:

Doctor: _____ Specialty: _____ Date first seen: _____

Referred by: _____ Treatment type: _____ Treatment frequency: _____

Treatment duration: _____ Currently treating? ☐ Yes ☐ No

Work restriction ☐ Yes ☐ No If yes, describe_____

Special tests: _____ Referred to: _____

Did treatment help? ☐ Yes ☐ No Comments: _____

Other Treatment Since Accident #2:

Doctor: _____ Specialty: _____ Date first seen: _____

Referred by: _____ Treatment type: _____ Treatment frequency: _____

Treatment duration: _____ Currently treating? ☐ Yes ☐ No

Work restriction ☐ Yes ☐ No If yes, describe_____

Special tests: _____ Referred to: _____

Did treatment help? ☐ Yes ☐ No Comments: _____

Chief Complaint 1		**Chief Complaint 2**	
Onset		Onset	
Pain Scale (1 to 10)		Pain Scale (1 to 10)	
Provocative		Provocative	
Palliative		Palliative	
Quality		Quality	
Radiation		Radiation	
Site (Location)		Site (Location)	
Time (Frequency)		Time (Frequency)	
Frequency: <25% Intermittent, 26-50% Occasional, 51-75% Frequent, > 76% Constant			
Chief Complaint 3		**Chief Complaint 4**	
Onset		Onset	
Pain Scale (1 to 10)		Pain Scale (1 to 10)	
Provocative		Provocative	
Palliative		Palliative	
Quality		Quality	
Radiation		Radiation	
Site (Location)		Site (Location)	
Time (Frequency)		Time (Frequency)	
Frequency: <25% Intermittent, 26-50% Occasional, 51-75% Frequent, > 76% Constant			

Treatment by Another Chiropractor: _____ Dates: _____

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Patient: _____ Page3

Previous Injuries, Hospitalizations, Surgeries

Date	Doctor/Hospital/ Condition	Treatment	Response (+) (-) (NC)	Treatment Duration	Test(s)	Test Result

Medications/Vitamins: _____

Allergies: _____

Family History: #1.Father, #2.Mother, #3.Sister (A, B, Etc), #4.Brother (A, B, Etc.)

Cancer	Diabetes	Heart Disease	CVA
HBP	Epilepsy	TB	Other
Other	Other	Other	Other

Psycho-Social History:

Changes to Activities of Daily Living Since the Accident: _____

_____

Recreational/Exercise: Type: _____ Freq. ____/Wk; Duration _____ Min. / Hrs: _____

Social Habits (Please Circle Appropriate Responses and Fill In The Blanks)

Tobacco: _____ Pack / ___Day, Week, For ___ Yrs; Chew _____ Yrs; Pipe _____ Yrs Caffeine (Soda, Coffee, Tea) _____/ Day

Alcohol _____ Glasses Of Wine, Beer, Mixed Drink/ Day, Wk, Mo.; Sleep Interrupted? ____ X's / Night For ____ Weeks Mo Yrs

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Patient: _____

Work Routine/Duties under Duress	**Able**		**Restricted**		**Unable**	**Comments**
Sit in office chair	1	2	3	4	5	
Stand erect	1	2	3	4	5	
Climb steps / stairs	1	2	3	4	5	
Stoop to retrieve	1	2	3	4	5	
Crouch to retrieve	1	2	3	4	5	
Kneel to retrieve	1	2	3	4	5	
Reach overhead	1	2	3	4	5	
Lift; waist to shoulder height	1	2	3	4	5	
Carry object, 100 feet	1	2	3	4	5	
Push	1	2	3	4	5	
Pull	1	2	3	4	5	
Balance	1	2	3	4	5	
Crawl	1	2	3	4	5	
Reach	1	2	3	4	5	
Handle objects appropriately	1	2	3	4	5	
Finger/Hand strength/coordination	1	2	3	4	5	

REVIEW OF SYSTEMS*: Please write all numbers that apply: #1. Presently have, #2. Previously had, #3. Related to accident*

GENERAL
___Allergy
___Chills
___Convulsions
___Dizziness
___Fainting
___Fatigue
___Fever
___Headache
___Sleep loss
___Weight loss
___Nervousness/depression
___Neuralgia
___Numbness
___Sweats
___Tremors

EYES, EARS, NOSE, THROAT
___Asthma
___Colds
___Sore throat
___Deafness
___Dental decay
___Earache/noises
___Ear discharge
___Sinus infection
___Enlarged glands
___Enlarged thyroid
___Nose bleeds
___Failing vision
___Far sighted
___Gum trouble
___Hay fever
___Hoarseness
___Nasal obstruction
___Near sighted

MUSCULOSKELETAL
___Arthritis
___Bursitis
___Foot Trouble
___Hernia
___Low back pain
___Lumbago
___Neck pain/stiffness
___Shoulder blade pain
Pain or numbness in:
___ Shoulders
___ Arms
___ Elbows
___ Hands
___ Hips
___ Legs
___ Knees
___ Feet
___Painful tailbone
___Poor posture
___Sciatica
___Spinal curvature

GENITO-URINARY
___Bedwetting
___Blood in urine
___Frequent urination
___Inability to control bladder
___Kidney infection or stones
___Painful urination
___Prostate trouble
___Pus in urine
___Painful menstruation
___Hot flashes
___Irregular cycle
___Lumps in breasts

CARDIOVASCULAR
___Hardening of arteries
___High blood pressure
___Low blood pressure
___Pain over heart
___Poor circulation
___Rapid heart beat
___Slow heart beat
___Swelling of ankles

RESPIRATORY
___Chest pain
___Chronic cough
___Difficult breathing
___Spitting up blood
___Spitting up phlegm
___Wheezing

GASTROINTESTINAL
___Belching or gas
___Colitis
___Colon trouble
___Constipation
___Diarrhea
___Difficult digestion
___Distention of abdomen
___Excessive hunger
___Gall bladder trouble
___Hemorrhoids
___Intestinal worms
___Jaundice
___Liver trouble
___Nausea
___Pain over stomach
___Poor appetite
___Vomiting
___Vomiting blood

Other:_____

Dr. Signature: _____Date _____