HEALTH QUESTIONNAIRE

Dear Patient: Please complete this questionnaire. Your answers will help us determine if we can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Please use a **No. 2 pencil** to fill in your answers. When filling in an **Other** bubble please explain in the space allowed. Fill in bubbles **completely** as indicated here: ⬭. **Erase** changes cleanly. Do **not fold** this form.

Patient Name:

MO	DAY	YEAR
①⑦	①	⓪
②⑧	②⑩	①
③⑨	③⑳	②
④⑩	④㉚	③
⑤⑪	⑤㊵	④
⑥⑫	⑥㊿	⑤
	⑩⑦	⑥
	⑳⑧	⑦
	㉚⑨	⑧
		⑨

DR# PATIENT NUMBER

⓪ ⓪ ⓪ ⓪ ⓪ ⓪ ⓪ ⓪ ⓪ ⓪ ⓪ ⓪ ⓪
① ① ① ① ① ① ① ① ① ① ① ① ①
② ② ② ② ② ② ② ② ② ② ② ② ②
③ ③ ③ ③ ③ ③ ③ ③ ③ ③ ③ ③ ③
④ ④ ④ ④ ④ ④ ④ ④ ④ ④ ④ ④ ④
⑤ ⑤ ⑤ ⑤ ⑤ ⑤ ⑤ ⑤ ⑤ ⑤ ⑤ ⑤ ⑤
⑥ ⑥ ⑥ ⑥ ⑥ ⑥ ⑥ ⑥ ⑥ ⑥ ⑥ ⑥ ⑥
⑦ ⑦ ⑦ ⑦ ⑦ ⑦ ⑦ ⑦ ⑦ ⑦ ⑦ ⑦ ⑦
⑧ ⑧ ⑧ ⑧ ⑧ ⑧ ⑧ ⑧ ⑧ ⑧ ⑧ ⑧ ⑧
⑨ ⑨ ⑨ ⑨ ⑨ ⑨ ⑨ ⑨ ⑨ ⑨ ⑨ ⑨ ⑨

Date Of Birth

Social Security #

Patient's Home Address

Phone **FAX**

Employer Business Address

Phone

Occupation

Referred By

Spouse Name

Social Security #

Sex:
- ○ Male
- ○ Female

Marital Status:
- ○ Single
- ○ Married
- ○ Widowed
- ○ Divorced
- ○ Other

Patient Resides With:
- ○ Lives Alone ○ Spouse ○ Parents
- ○ Children ○ Other

Children: ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5+

A. MAJOR COMPLAINTS

1. What are your major complaints?

○ None	Pain	Numbness	Tingling
Head	Ⓗ	Ⓗ	Ⓗ
Neck	Ⓝ	Ⓝ	Ⓝ
Upper Back	Ⓤ	Ⓤ	Ⓤ
Mid Back	Ⓜ	Ⓜ	Ⓜ
Lower Back	Ⓛ	Ⓛ	Ⓛ

	Pain R	Pain L	Numbness R	Numbness L	Tingling R	Tingling L
Shoulder	Ⓢ	Ⓢ	Ⓢ	Ⓢ	Ⓢ	Ⓢ
Arm	Ⓐ	Ⓐ	Ⓐ	Ⓐ	Ⓐ	Ⓐ
Forearm	Ⓕ	Ⓕ	Ⓕ	Ⓕ	Ⓕ	Ⓕ
Hand	Ⓗ	Ⓗ	Ⓗ	Ⓗ	Ⓗ	Ⓗ
Buttock	Ⓑ	Ⓑ	Ⓑ	Ⓑ	Ⓑ	Ⓑ
Hip	Ⓗ	Ⓗ	Ⓗ	Ⓗ	Ⓗ	Ⓗ
Thigh	Ⓣ	Ⓣ	Ⓣ	Ⓣ	Ⓣ	Ⓣ
Leg	Ⓛ	Ⓛ	Ⓛ	Ⓛ	Ⓛ	Ⓛ
Foot	Ⓕ	Ⓕ	Ⓕ	Ⓕ	Ⓕ	Ⓕ

2. Currently your pain is aggravated by
- ○ Coughing
- ○ Sneezing
- ○ Straining At Stool
- ○ Neck Movement
- ○ Reaching
- ○ Other
- ○ Lifting
- ○ Bending
- ○ Sitting
- ○ Standing
- ○ Walking

3. Since your symptoms began, have you noticed a change in
- ○ Bowel Function
- ○ Bladder Function
- ○ Ability To Maintain An Erection

B. REVIEW OF SYSTEMS

Are you presently suffering (or within the past six months suffered) from any of the following?

1. a. GENERAL
- ○ Normal
- ○ Fatigue
- ○ Weakness
- ○ Fever
- ○ Chills
- ○ Weight Change
- ○ Night Sweats
- ○ Other

b. SKIN
- ○ Normal
- ○ Rash
- ○ Redness
- ○ Itching
- ○ Eczema
- ○ Hair Changes
- ○ Nail Changes
- ○ Other

c. NEUROLOGIC
- ○ Normal
- ○ Headache
- ○ Dizziness
- ○ Fainting
- ○ Convulsions
- ○ Other

d. EYES

○ Normal	Right	Left
Vision Trouble	○	○
Pain	○	○
Discharge	○	○
Other	○	○

e. EARS

○ Normal	Right	Left
Hearing Trouble	○	○
Ringing	○	○
Pain	○	○
Discharge	○	○
Other	○	○

f. NOSE
- ○ Normal
- ○ Pain
- ○ Bleeding
- ○ Absence Of Smell
- ○ Other

g. MOUTH/THROAT
- ○ Normal
- ○ Sores
- ○ Bleeding
- ○ Absence Of Taste
- ○ Abnormal Taste
- ○ Other

h. HEART/LUNGS
- ○ Normal
- ○ Cough
- ○ Wheezing
- ○ Difficulty Breathing
- ○ Swollen Extremities
- ○ Blue Extremities
- ○ Murmur
- ○ Chest Pain
- ○ Palpitations
- ○ Other

i. BREASTS
- ○ Normal
- ○ Lumps In Breast(s)
- ○ Redness/Itching
- ○ Pain
- ○ Dimpling
- ○ Discharge
- ○ Other

j. STOMACH/INTESTINES
- ○ Normal
- ○ Decreased Appetite
- ○ Increased Appetite
- ○ Abdominal Pain
- ○ Vomiting
- ○ Diarrhea
- ○ Constipation
- ○ Other

k. REPRODUCTIVE/URINATION
- ○ Normal
- ○ Inability To Hold Urine
- ○ Painful Urination
- ○ Frequent Urination
- ○ Irregular Menstruation
- ○ Painful Menstruation
- ○ Abnormal Vaginal Bleeding
- ○ Impotence
- ○ Sterility
- ○ Other

l. GLANDULAR
- ○ Normal
- ○ Heat/Cold Intolerance
- ○ Sugar In Urine
- ○ Goiter
- ○ Tremor
- ○ Other

m. MENTAL
- ○ Normal
- ○ Anxiety
- ○ Depression
- ○ Memory Loss or Impairment
- ○ Phobias
- ○ Mood Swings
- ○ Other

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2. What are your habits?

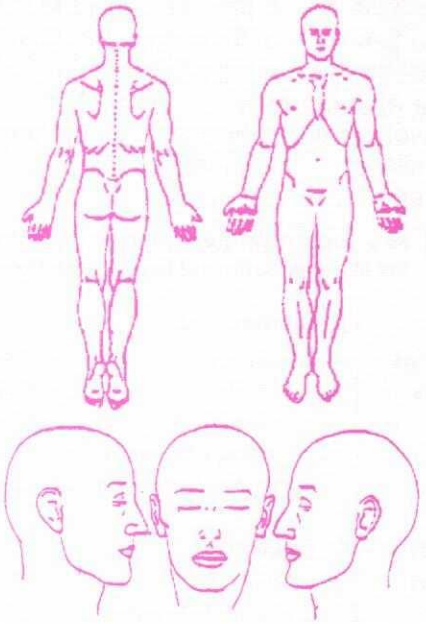
	Never	Occasionally	Moderately	Excessively
Smoking	S	S	S	S
Alcohol	A	A	A	A
Recreational Drugs	R	R	R	R
Exercise	E	E	E	E

3. FAMILY HISTORY

	Cancer	Diabetes	Heart Trouble	High Blood Pressure	Stroke	Multiple Sclerosis	Headaches	Neck Problems	Back Problems	Disc Problems	Joint Problems	Arthritis	Pinched Nerve	Osteoporosis	Scoliosis	Bad Posture
Father	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Mother	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Brothers	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B
Sisters	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
Children	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C

C. PAIN DIAGRAMS

Please mark the location of your pain on these figures



D. MEDICAL HISTORY

1. HEALTH CARE

	Yes	No
a. Have you been to a chiropractor	Y	N
b. Do you have a family physician	Y	N
c. WOMEN:		
To the best of your knowledge are you pregnant	Y	N
Are you under the regular care of an OB-GYN	Y	N
d. Have you been hospitalized in the past five years	Y	N
e. Are you currently taking any medication	Y	N

- ○ Anti-inflammatory (Aspirin, Motrin, etc.)
- ○ Muscle Relaxants
- ○ Pain Medication/Analgesic
- ○ Tranquilizers
- ○ Birth Control Pills
- ○ Other

2. Which of the following illnesses have you had?

- ○ *No Previous Conditions/Illnesses*
- ○ Arthritis
- ○ Asthma
- ○ Sinus Trouble
- ○ Hay Fever
- ○ Allergies
- ○ Tuberculosis
- ○ Diabetes
- ○ Epilepsy
- ○ Thyroid Trouble
- ○ High Blood Pressure
- ○ Low Blood Pressure
- ○ Heart Trouble
- ○ HIV/ARC
- ○ AIDS
- ○ Sexually Transmitted Disease
- ○ Ulcer
- ○ Cancer
- ○ Polio
- ○ Rheumatic Fever
- ○ Serious Injury
- ○ Bone Fracture
- ○ Dislocated Joints
- ○ Spinal Disc Disease
- ○ Multiple Sclerosis
- ○ Scoliosis
- ○ Mental/Emotional Difficulty
- ○ Prostate Trouble
- ○ Kidney Trouble
- ○ Other

E. INSURANCE INFORMATION

	Yes	No
1. Is your condition due to an automobile accident	Y	N
Date of Accident		
Have You filed an accident report	Y	N
2. Is your condition due to a job injury	Y	N
Date of Injury		
Have You filed an injury report	Y	N
3. Do you have health insurance	Y	N
Company		
Policy #		
4. Are you covered by Medicare	Y	N
Medicare #		

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

F. PAYMENT

I WILL BE PAYING TODAY BY:

○ Cash ○ Check ○ Credit Card

○ MasterCard ○ Visa ○ American Express

Account # _____ Exp. Date _____

All accounts not paid within 90 days will automatically be put through on your credit card.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____

Doctor's Signature _____ Date _____

AUTOMOBILE CRASH QUESTIONNAIRE

Dear Patient:
This questionnaire will allow you to describe your automobile accident in detail. Please complete it carefully as the information provided will assist the doctor in evaluating and documenting your condition. THANK YOU.

Patient Name:

MO	DAY	YEAR	DR#	PATIENT NUMBER
1 7	1	0	0 0 0	0 0 0 0 0 0 0 0 0 0 0 0
2 8	2	10 1	1 1 1	1 1 1 1 1 1 1 1 1 1 1 1
3 9	3	20 2	2 2 2	2 2 2 2 2 2 2 2 2 2 2 2
4 10	4	30 3	3 3 3	3 3 3 3 3 3 3 3 3 3 3 3
5 11	5	40 4	4 4 4	4 4 4 4 4 4 4 4 4 4 4 4
6 12	6	50 5	5 5 5	5 5 5 5 5 5 5 5 5 5 5 5
	10 7	60 6	6 6 6	6 6 6 6 6 6 6 6 6 6 6 6
	20 8	70 7	7 7 7	7 7 7 7 7 7 7 7 7 7 7 7
	30 9	80 8	8 8 8	8 8 8 8 8 8 8 8 8 8 8 8
		90 9	9 9 9	9 9 9 9 9 9 9 9 9 9 9 9

Use a **No. 2 pencil** to mark your answers. When marking in an **Other** bubble please explain in the space allowed. Fill in bubbles **completely** as indicated here: ⬭. **Erase** changes cleanly. Do **not fold** form.

A. VEHICLE YOU WERE IN

1. Vehicle type?
- ⬭ Car ⬭ Pickup
- ⬭ Van ⬭ Truck
- ⬭ Station Wagon ⬭ Bus
- ⬭ Other

2. Vehicle size?
- ⬭ Subcompact ⬭ Full-Size
- ⬭ Compact ⬭ Mini
- ⬭ Mid-Size ⬭ Light
- ⬭ Other

3. What was your location in the vehicle?
- ⬭ Driver ⬭ Front Passenger ⬭ Rear Passenger
- **Passenger Location:** ⬭ Left ⬭ Middle ⬭ Right
- ⬭ Other

4. What was the vehicle you were in doing?

Mark only ONE bubble below to answer this question

a. Vehicle stopped for
- ⬭ Traffic Light ⬭ Intersection ⬭ Stop Sign ⬭ Traffic
- ⬭ Pedestrian ⬭ Parked
- ⬭ Other

b. Vehicle slowing down for
- ⬭ Traffic Light ⬭ Intersection ⬭ Stop Sign ⬭ Traffic
- ⬭ Pedestrian ⬭ Turning ⬭ Parking
- ⬭ Other

c. Vehicle moving
- ⬭ Slowly ⬭ Moderately ⬭ Fast
- ⬭ ___ MPH ⬭ Accelerating
- ⬭ Other

d. Vehicle doing other
- ⬭ Other

5. What damage did the vehicle you were in sustain?
- ⬭ Minimal ⬭ Moderate ⬭ Extensive ⬭ Totaled
- ⬭ Unsure ⬭ Other

B. IF OTHER VEHICLES INVOLVED IN ACCIDENT

1. First Vehicle To Strike Vehicle You Were In

a. Vehicle type?
- ⬭ Car ⬭ Pickup
- ⬭ Van ⬭ Truck
- ⬭ Station Wagon ⬭ Bus
- ⬭ Other

b. Vehicle size?
- ⬭ Subcompact ⬭ Full-Size
- ⬭ Compact ⬭ Mini
- ⬭ Mid-Size ⬭ Light
- ⬭ Other

c. How did this vehicle strike the vehicle you were in?
- ⬭ Head On ⬭ From Right ⬭ From Left ⬭ Rear Ended
- ⬭ Sideswiped On Right ⬭ Sideswiped On Left
- ⬭ Other

d. What damage did this vehicle sustain?
- ⬭ Minimal ⬭ Moderate ⬭ Extensive ⬭ Totaled
- ⬭ Unsure ⬭ Other

2. Second Vehicle To Strike Vehicle You Were In

a. Vehicle type?
- ⬭ Car ⬭ Pickup
- ⬭ Van ⬭ Truck
- ⬭ Station Wagon ⬭ Bus
- ⬭ Other

b. Vehicle size?
- ⬭ Subcompact ⬭ Full-Size
- ⬭ Compact ⬭ Mini
- ⬭ Mid-Size ⬭ Light
- ⬭ Other

c. How did this vehicle strike the vehicle you were in?
- ⬭ Head On ⬭ From Right ⬭ From Left ⬭ Rear Ended
- ⬭ Sideswiped On Right ⬭ Sideswiped On Left
- ⬭ Other

d. What damage did this vehicle sustain?
- ⬭ Minimal ⬭ Moderate ⬭ Extensive ⬭ Totaled
- ⬭ Unsure ⬭ Other

3. Describe Other Vehicles To Strike Vehicle You Were In
- ⬭ Vehicle Type: ⬭ How it struck:
- ⬭ Vehicle Size: ⬭ Damage:

4. Were traffic citations issued as a result of the accident?
- ⬭ No Citations issued ⬭ Driver Of Other Vehicle
- ⬭ Driver Of Vehicle You Were In ⬭ You ⬭ Unsure

C. CONDITIONS AT TIME OF ACCIDENT

1. What time of day did the accident occur?
- ⬭ Daylight ⬭ Dawn ⬭ Dusk ⬭ Night
- ⬭ Other

2. What was the condition of the road?
- ⬭ Dry ⬭ Damp ⬭ Wet ⬭ Snow Covered
- ⬭ Icy ⬭ Other

3. Visibility

a. What was the visibility at impact?
- ⬭ Good ⬭ Fair ⬭ Poor
- ⬭ Other

b. If visibility was poor, why?
- ⬭ Sun Light ⬭ Darkness ⬭ Rain ⬭ Snow
- ⬭ Fog ⬭ Traffic
- ⬭ Other

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D. AT MOMENT OF IMPACT

1. Were you prepared for the accident?

- ○ Accident A Complete Surprise
- ○ Aware Of Impending Collision ○ And Braced For Impact

2. Foot On Brake Pedal

a. Was your foot on brake pedal at impact? ○ Yes ○ No

b. Was it knocked off pedal by impact? ○ Yes ○ No

3. Use Of Restraints

a. Restraint Belts

1. Were you wearing a restraint belt? ○ Yes ○ No

2. What type of restraint belt were you wearing?

○ Shoulder-Lap Belt ○ Shoulder Belt ○ Lap Belt

b. Headrests

1. Was vehicle equipped with headrests? ○ Yes ○ No

2. What position was the headrest in?

○ Low ○ Middle ○ High ○ Don't Know

c. Air Bags

1. Was vehicle equipped with air bags?

○ Yes ○ No ○ Unsure

2. Did the air bags deploy? ○ Yes ○ No

4. Your Body

a. What was your body position at impact?

- ○ Straight ○ Slouched Forward **Rotated:** ○ Right ○ Left
- ○ Don't Recall ○ Other

b. What direction was your body thrown?

- ○ Forward\Backward ○ Backward\Forward ○ Sideways
- ○ Across Vehicle ○ Outside Vehicle ○ Under Vehicle
- ○ Don't Recall ○ Other

5. Your Head And Neck

a. What position were your head/neck in at impact?

- ○ Straight ○ Tilted Forward **Rotated:** ○ Right ○ Left
- ○ Don't Recall ○ Other

b. Through what motion were your head/neck pitched?

- ○ Forward\Backward ○ Backward\Forward ○ Sideways
- ○ Don't Recall ○ Other

E. RESULT OF IMPACT

1. Which objects in the vehicle did the force of the collision cause your body to strike?

a. Head

○ Steering Wheel	○ Dashboard	○ Windshield
○ Right Side Door	○ Left Side Door	○ Armrest
○ Right Window	○ Left Window	○ Headrest
○ Ceiling	○ Console	○ Shift Lever
○ Front Seat	○ Rear View Mirror	
○ Other		

b. Right Upper Extremity (Arm)

○ Steering Wheel	○ Dashboard	○ Windshield
○ Right Side Door	○ Left Side Door	○ Armrest
○ Right Window	○ Left Window	○ Headrest
○ Ceiling	○ Console	○ Shift Lever
○ Front Seat	○ Rear View Mirror	
○ Other		

c. Left Upper Extremity (Arm)

○ Steering Wheel	○ Dashboard	○ Windshield
○ Right Side Door	○ Left Side Door	○ Armrest
○ Right Window	○ Left Window	○ Headrest
○ Ceiling	○ Console	○ Shift Lever
○ Front Seat	○ Rear View Mirror	
○ Other		

d. Torso

○ Steering Wheel	○ Dashboard	○ Windshield
○ Right Side Door	○ Left Side Door	○ Armrest
○ Right Window	○ Left Window	○ Headrest
○ Ceiling	○ Console	○ Shift Lever
○ Front Seat	○ Rear View Mirror	
○ Other		

e. Right Lower Extremity (Leg)

○ Steering Wheel	○ Dashboard	○ Windshield
○ Right Side Door	○ Left Side Door	○ Armrest
○ Right Window	○ Left Window	○ Headrest
○ Ceiling	○ Console	○ Shift Lever
○ Front Seat	○ Rear View Mirror	
○ Other		

f. Left Lower Extremity (Leg)

○ Steering Wheel	○ Dashboard	○ Windshield
○ Right Side Door	○ Left Side Door	○ Armrest
○ Right Window	○ Left Window	○ Headrest
○ Ceiling	○ Console	○ Shift Lever
○ Front Seat	○ Rear View Mirror	
○ Other		

2. Did your body strike any other objects?

○ Description Of Other Objects Your Body Hit:

F. ADDITIONAL INFORMATION

○ Additional Information About Your Automobile Accident:

Patient's Or Guardian Signature: **Date:**

ACCIDENT / INJURY QUESTIONNAIRE

Patient Name:

MO	DAY	YEAR	DR#	PATIENT NUMBER

Dear Patient:
This questionnaire will allow you to describe your automobile accident in detail. Please complete it carefully as the information provided will assist the doctor in evaluating and documenting your condition. THANK YOU.

Use a **No. 2 pencil** to mark your answers. When marking in an **Other** bubble please explain in the space allowed. Fill in bubbles **completely** as indicated here: ⬭. **Erase** changes cleanly. Do **not fold** form.

A. DATE AND TIME OF ACCIDENT / INJURY

○ Date: / / Time: : am / pm

B. DESCRIPTION OF ACCIDENT / INJURY

○ Automobile Crash Questionnaire Marked **(Skip Section B)**
○ Workmen's Compensation Accident / Injury
○ Slip/Fall Accident ○ Pedestrian Accident
Other: ○ Accident ○ Injury

1. What was the cause of your accident / injury?

2. Describe in your own words what happened:

C. IMMEDIATELY AFTER ACCIDENT / INJURY

1. Did you lose consciousness?
○ Yes ○ No ○ Don't Know

2. How did you feel?
○ Confused ○ Dazed ○ Dizzy ○ Nervous
○ Weak ○ Other

3. Where did you immediately develop pain?

○ Head	® Ⓛ Shoulders	® Ⓛ Buttocks
○ Neck	® Ⓛ Arms	® Ⓛ Hips
○ Upper / Mid Back	® Ⓛ Elbows	® Ⓛ Thighs
○ Lower Back	® Ⓛ Forearms	® Ⓛ Knees
○ Pelvis	® Ⓛ Wrists	® Ⓛ Legs
○ Chest / Rib Cage	® Ⓛ Hands	® Ⓛ Ankles
○ Abdomen		® Ⓛ Feet
○ Other		

4. If there were lacerations (cuts), where were they?

○ Head	® Ⓛ Shoulders	® Ⓛ Buttocks
○ Neck	® Ⓛ Arms	® Ⓛ Hips
○ Upper / Mid Back	® Ⓛ Elbows	® Ⓛ Thighs
○ Lower Back	® Ⓛ Forearms	® Ⓛ Knees
○ Pelvis	® Ⓛ Wrists	® Ⓛ Legs
○ Chest / Rib Cage	® Ⓛ Hands	® Ⓛ Ankles
○ Abdomen		® Ⓛ Feet
○ Other		

5. Describe any other significant injury:

6. Emergency Care At Accident/Injury Site
a. Did you receive emergency care? ○ Yes ○ No

b. What type of emergency care did you receive?
○ Bandages ○ Splints ○ Brace ○ Neck Collar
○ Other

7. Destination After Accident / Injury

a. Where did you go?
○ Hospital ○ Home
○ School ○ Work
○ Other

b. By whom were you driven?
○ Myself ○ Ambulance
○ Friend ○ Family Member
○ Other

D. HOSPITAL VISIT AFTER ACCIDENT / INJURY

1. When did you go to the hospital?
○ Immediately ○ Later That Day ○ Next Day ○ Days Later
○ Date / / ○ Other

○ Hospital Name:

○ Examined By Doctor:

Admitted: ○ Yes ○ No ○ Date Discharged: / /

2. If x-rays were taken, of what body part(s)?

○ Head	® Ⓛ Shoulders	® Ⓛ Buttocks
○ Neck	® Ⓛ Arms	® Ⓛ Hips
○ Upper / Mid Back	® Ⓛ Elbows	® Ⓛ Thighs
○ Lower Back	® Ⓛ Forearms	® Ⓛ Knees
○ Pelvis	® Ⓛ Wrists	® Ⓛ Legs
○ Chest / Rib Cage	® Ⓛ Hands	® Ⓛ Ankles
○ Abdomen		® Ⓛ Feet
○ Other		

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D. HOSPITAL VISIT AFTER ACCIDENT / INJURY

3. If a CAT Scan was performed, of what body part(s)?

○ Head ○ Upper / Mid Back ○ Chest / Rib Cage
○ Neck ○ Lower Back ○ Abdomen
○ Other

4. If a MRI was performed, of what body part(s)?

○ Head ○ Upper / Mid Back ○ Chest / Rib Cage
○ Neck ○ Lower Back ○ Abdomen
○ Other

5. What was the diagnosis given at the hospital?

a. Head
○ Concussion ○ Skull Fracture ○ Lacerations
○ Contusions ○ Other

b. Jaw
○ Strain ○ Sprain ○ Dislocation
○ Fracture ○ Whiplash ○ Lacerations
○ Contusions ○ Other

c. Neck
○ Strain ○ Sprain ○ Dislocation
○ Fracture ○ Whiplash ○ Disc Injury
○ Lacerations ○ Contusions
○ Other

d. Upper / Middle Back
○ Strain ○ Sprain ○ Dislocation
○ Fracture ○ Disc Injury ○ Lacerations
○ Contusions ○ Other

e. Lower Back
○ Strain ○ Sprain ○ Dislocation
○ Fracture ○ Disc Injury ○ Lacerations
○ Contusions ○ Other

f. Pelvis
○ Strain ○ Sprain ○ Dislocation
○ Fracture ○ Lacerations ○ Contusions
○ Other

g. Chest / Rib Cage
○ Strain ○ Sprain ○ Dislocation
○ Fracture ○ Lacerations ○ Contusions
○ Other

h. Abdomen
○ Strain ○ Lacerations ○ Contusions
○ Other

i. Shoulders
Ⓡ Ⓛ Strain Ⓡ Ⓛ Sprain Ⓡ Ⓛ Dislocation
Ⓡ Ⓛ Fracture Ⓡ Ⓛ Lacerations Ⓡ Ⓛ Contusions
Ⓡ Ⓛ Other

j. Arms
Ⓡ Ⓛ Strain Ⓡ Ⓛ Sprain Ⓡ Ⓛ Dislocation
Ⓡ Ⓛ Fracture Ⓡ Ⓛ Lacerations Ⓡ Ⓛ Contusions
Ⓡ Ⓛ Other

k. Elbows
Ⓡ Ⓛ Strain Ⓡ Ⓛ Sprain Ⓡ Ⓛ Dislocation
Ⓡ Ⓛ Fracture Ⓡ Ⓛ Lacerations Ⓡ Ⓛ Contusions
Ⓡ Ⓛ Other

l. Forearms
Ⓡ Ⓛ Strain Ⓡ Ⓛ Sprain Ⓡ Ⓛ Dislocation
Ⓡ Ⓛ Fracture Ⓡ Ⓛ Lacerations Ⓡ Ⓛ Contusions
Ⓡ Ⓛ Other

m. Wrists
Ⓡ Ⓛ Strain Ⓡ Ⓛ Sprain Ⓡ Ⓛ Dislocation
Ⓡ Ⓛ Fracture Ⓡ Ⓛ Lacerations Ⓡ Ⓛ Contusions
Ⓡ Ⓛ Other

n. Hands / Fingers
Ⓡ Ⓛ Strain Ⓡ Ⓛ Sprain Ⓡ Ⓛ Dislocation
Ⓡ Ⓛ Fracture Ⓡ Ⓛ Lacerations Ⓡ Ⓛ Contusions
Ⓡ Ⓛ Other

o. Buttocks
Ⓡ Ⓛ Strain Ⓡ Ⓛ Sprain Ⓡ Ⓛ Lacerations
Ⓡ Ⓛ Contusions Ⓡ Ⓛ Other

p. Hips
Ⓡ Ⓛ Strain Ⓡ Ⓛ Sprain Ⓡ Ⓛ Dislocation
Ⓡ Ⓛ Fracture Ⓡ Ⓛ Lacerations Ⓡ Ⓛ Contusions
Ⓡ Ⓛ Other

q. Thighs
Ⓡ Ⓛ Strain Ⓡ Ⓛ Sprain Ⓡ Ⓛ Dislocation
Ⓡ Ⓛ Fracture Ⓡ Ⓛ Lacerations Ⓡ Ⓛ Contusions
Ⓡ Ⓛ Other

r. Knees
Ⓡ Ⓛ Strain Ⓡ Ⓛ Sprain Ⓡ Ⓛ Dislocation
Ⓡ Ⓛ Fracture Ⓡ Ⓛ Lacerations Ⓡ Ⓛ Contusions
Ⓡ Ⓛ Other

s. Legs
Ⓡ Ⓛ Strain Ⓡ Ⓛ Sprain Ⓡ Ⓛ Dislocation
Ⓡ Ⓛ Fracture Ⓡ Ⓛ Lacerations Ⓡ Ⓛ Contusions
Ⓡ Ⓛ Other

t. Ankles
Ⓡ Ⓛ Strain Ⓡ Ⓛ Sprain Ⓡ Ⓛ Dislocation
Ⓡ Ⓛ Fracture Ⓡ Ⓛ Lacerations Ⓡ Ⓛ Contusions
Ⓡ Ⓛ Other

u. Feet / Toes
Ⓡ Ⓛ Strain Ⓡ Ⓛ Sprain Ⓡ Ⓛ Dislocation
Ⓡ Ⓛ Fracture Ⓡ Ⓛ Lacerations Ⓡ Ⓛ Contusions
Ⓡ Ⓛ Other

v. Other
○ Strain ○ Sprain ○ Dislocation
○ Fracture ○ Lacerations ○ Contusions

w. Describe any additional diagnosis given:

D. HOSPITAL VISIT AFTER ACCIDENT / INJURY

6. What treatment was administered at the hospital?

- ○ Oral Medication
- ○ Injection
- ○ Topical Antiseptics
- ○ Bandages
- ○ Sutures
- ○ Ice Packs
- ○ Hot Packs
- ○ Other
- ○ Splint
- ○ Cast
- ○ Brace
- ○ Collar
- ○ Support
- ○ Surgery

7. Instructions Given When Discharged From Hospital

a. Were you told to see?

- ○ General Practitioner
- ○ Chiropractor
- ○ Neurologist
- ○ Physical Therapist
- ○ Orthopedist
- ○ Internist
- ○ General Surgeon
- ○ Plastic Surgeon
- ○ Other

b. What recommendations were made?

- ○ No Further Care
- ○ No Follow-up Instructions
- ○ Observation
- ○ Rest
- ○ Ice
- ○ Heat
- ○ Collar
- ○ Support
- ○ Time Off Work
- ○ Other

c. Were medications prescribed?

- ○ Pain
- ○ Anti-inflammatory
- ○ Antibiotic
- ○ Nervousness
- ○ Other

E. FOLLOWING THE ACCIDENT / INJURY

1. How much later did additional symptoms develop?

- ○ Immediately
- ○ Hours
- ○ That Evening
- ○ Next Morning
- ○ Days
- ○ Week
- ○ Month

2. What additional symptoms developed?

a. Head

- ○ Pain
- ○ Stiffness
- ○ Numbness
- ○ Tingling
- ○ Other

b. Jaw

- ○ Pain
- ○ Stiffness
- ○ Numbness
- ○ Tingling
- ○ Other

c. Neck

- ○ Pain
- ○ Stiffness
- ○ Numbness
- ○ Tingling
- ○ Other

d. Upper / Middle Back

- ○ Pain
- ○ Stiffness
- ○ Numbness
- ○ Tingling
- ○ Other

e. Lower Back

- ○ Pain
- ○ Stiffness
- ○ Numbness
- ○ Tingling
- ○ Other

f. Pelvis

- ○ Pain
- ○ Stiffness
- ○ Numbness
- ○ Tingling
- ○ Other

g. Chest / Rib Cage

- ○ Pain
- ○ Stiffness
- ○ Numbness
- ○ Tingling
- ○ Other

h. Abdomen

- ○ Pain
- ○ Stiffness
- ○ Numbness
- ○ Tingling
- ○ Other

i. Shoulders

- ○ ○ Pain
- ○ ○ Stiffness
- ○ ○ Numbness
- ○ ○ Tingling
- ○ ○ Other

j. Arms

- ○ ○ Pain
- ○ ○ Stiffness
- ○ ○ Numbness
- ○ ○ Tingling
- ○ ○ Other

k. Elbows

- ○ ○ Pain
- ○ ○ Stiffness
- ○ ○ Numbness
- ○ ○ Tingling
- ○ ○ Other

l. Forearms

- ○ ○ Pain
- ○ ○ Stiffness
- ○ ○ Numbness
- ○ ○ Tingling
- ○ ○ Other

m. Wrists

- ○ ○ Pain
- ○ ○ Stiffness
- ○ ○ Numbness
- ○ ○ Tingling
- ○ ○ Other

n. Hands / Fingers

- ○ ○ Pain
- ○ ○ Stiffness
- ○ ○ Numbness
- ○ ○ Tingling
- ○ ○ Other

o. Buttocks

- ○ ○ Pain
- ○ ○ Stiffness
- ○ ○ Numbness
- ○ ○ Tingling
- ○ ○ Other

p. Hips

- ○ ○ Pain
- ○ ○ Stiffness
- ○ ○ Numbness
- ○ ○ Tingling
- ○ ○ Other

q. Thighs

- ○ ○ Pain
- ○ ○ Stiffness
- ○ ○ Numbness
- ○ ○ Tingling
- ○ ○ Other

r. Knees

- ○ ○ Pain
- ○ ○ Stiffness
- ○ ○ Numbness
- ○ ○ Tingling
- ○ ○ Other

s. Legs

- ○ ○ Pain
- ○ ○ Stiffness
- ○ ○ Numbness
- ○ ○ Tingling
- ○ ○ Other

t. Ankles

- ○ ○ Pain
- ○ ○ Stiffness
- ○ ○ Numbness
- ○ ○ Tingling
- ○ ○ Other

u. Feet / Toes

- ○ ○ Pain
- ○ ○ Stiffness
- ○ ○ Numbness
- ○ ○ Tingling
- ○ ○ Other

v. Other ○

3. Since your accident / injury have you suffered from?

- ○ Blurred Vision
- ○ Double Vision
- ○ Reduced Vision
- ○ Impaired Hearing
- ○ Ringing In Ears
- ○ Chest Pain
- ○ Difficulty Breathing
- ○ Palpitations
- ○ Constipation
- ○ Diarrhea
- ○ Nausea
- ○ Vomiting
- ○ Frequent Urination
- ○ Inability To Hold Urine
- ○ Painful Urination

E. FOLLOWING THE ACCIDENT/INJURY (Continued)

4. Additionally have you experienced any of the following?

◯ Anxiety	◯ Convulsions	◯ Restlessness
◯ Depression	◯ Dizziness	◯ Insomnia
◯ Mood Swings	◯ Headaches	◯ Light Sensitivity
◯ Nervousness	◯ Fainting	◯ Reduced Appetite
◯ Poor Memory	◯ Loss Of Balance	◯ Weakness
◯ Tension	◯ Fatigue	◯ Weight Gain
◯ Other		◯ Weight Loss

5. Are you restricted in any of the following areas as a result of this accident/injury?

◯ Daily Living ◯ Occupational/Work ◯ Recreational Activities
◯ Other

6. Have you missed work due to this accident / injury?

◯ Missed No Work ◯ Limited Work Activity
◯ Missed Work From: / / To: / /
◯ Other

7. Did you self treat your symptoms?

◯ Ice ◯ Heat ◯ Bed Rest ◯ Over-The-Counter Medication
◯ Other

8. Did you seek medical care elsewhere?

a. General Practitioner ◯ Name:
◯ Diagnosis And Treatment Recommendation:

b. Internist ◯ Name:
◯ Diagnosis And Treatment Recommendation:

c. Chiropractor ◯ Name:
◯ Diagnosis And Treatment Recommendation:

d. Neurologist ◯ Name:
◯ Diagnosis And Treatment Recommendation:

e. Orthopedist ◯ Name:
◯ Diagnosis And Treatment Recommendation:

f. General Surgeon ◯ Name:
◯ Diagnosis And Treatment Recommendation:

g. Plastic Surgeon ◯ Name:
◯ Diagnosis And Treatment Recommendation:

h. Psychologist ◯ Name:
◯ Diagnosis And Treatment Recommendation:

i. Other ◯ Name: ◯ Type:
◯ Diagnosis And Treatment Recommendation:

9. Have you had any of the following tests?

◯ CT Scan ◯ MRI ◯ Electrodiagnostic Studies
◯ Other

10. What is the reason for seeking today's consultation?

◯ Persisting Complaints ◯ Worsening Of Symptoms
◯ Other

F. INSURANCE / ATTORNEY INFORMATION

	Yes	No
1. Have you contacted an insurance adjuster or representative regarding this claim?	Ⓨ	Ⓝ
Company:		
Adjuster:		
Claim #:		
2. Have you engaged services of an attorney?	Ⓨ	Ⓝ
Attorney:		
Address:		
City: **State:** **Zip:**		
Phone:		
3. Have you filed an accident / injury report?	Ⓨ	Ⓝ
4. Have you filed for insurance benefits?	Ⓨ	Ⓝ

SCANTRON EW-266182-1:6

Patient's Or Guardian Signature: **Date:**

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PLEASE MAKE NO MARKS IN THIS AREA