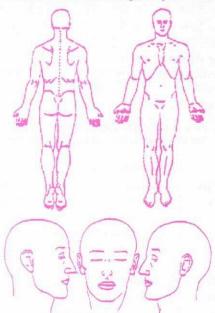
Dear Patient:	Plea	se cor	mplete	this a	uestic	AIRE	Your answers will help u	15 8		ent Nan		ENT NILIMBED
letermine if we	e can	help v	ou. If	we do	nots	incerely	believe your condition w	rill K		AT TE	DR# PAII	ENT NUMBER
espond satisfa								Œ	0	0		
lease use a N lease explain	in the	encil	to fill in	youra	answe Fill in	hubble	en filling in an Other bubb completely as indicate	le ②	1	200		
ere: . E	rase	hange	es clea	nly. D	o not	fold this	form.	20	1	3 20	0 0000000	2000000
									(ID)	4 30		DOOOO
ate Of Birth			4-7-					•	(ID)	3 40		DODOOO
ocial Secur	ity#						Sex:	6	12	(B) (50)		
							□ ○Male			0000		The second secon
atient's Hon	ne A	dres	S				Female		1000	0000		
				188			Marital Status:		30	900		And the second s
							Single Married			90		
							Widowed	P			des With:	Devente
hone			FAX	THE I			Divorced			ves Alc	ne Spouse o	Parents
							Other	C	hildre		0 01 02 03 d	-A - E !
mployer Bu	sines	ss Ad	dress	5								
							B.REVIEW OF S	SYSTE	MS	Are yo	ou presently suffering (or within the pas
							1. a. GENERAL			six mo	nths suffered) from any	of the following?
								Chills		1	. HEART/LUNGS	
none								Weigh	t Chan		Normal	Blue Extremitie
ccupation								ONight S			Cough	Murmur
ooupation								Other			○ Wheezing	Chest Pain
eferred By								The state of the s			Difficulty Breathing	Palpitations
				zirit.			b. SKIN				Swollen Extremities	Other
pouse Nam	ne .						Normal	○ Eczem	na			
ocial Securi	ity#							OHair C		s i	BREASTS	
				_				○Nail Cl	Marie Control		○ Normal	Dimpling
MAJOR C	COM	PLA	INTS				Oltching	Other			CLumps In Breast(s)	Discharge
1. What are	you	r maj	or co	mplai	nts?		Sales and the sa				Redness/Itching	Other
None	P	ain	Num	bness	Tin	gling	c. NEUROLOGIC				Pain	
Head	(HD	(D	(B	<u>Normal</u>	Faintin	g			
Neck	(ND		N	(ND I	Headache	○Convu	Isions	. j.	STOMACH/INTESTINES	
Upper Back		D		D	(D	ODizziness	Other			O Normal	○ Vomiting
Mid Back		MD		MD		M	The latest the second				Decreased Appetite	Diarrhea
Lower Back		D		D		D	d. EYES				Increased Appetite	Constipation
Treside I	R	L	R	L	R	L	○ <u>Normal</u>		t Left		Abdominal Pain	Other
Shoulder	(\$)	(3)	3	(\$)	3	(3)	Vision Trouble	0	0			
Arm	(A)	(A)	(A)	(A)	(A)	(A)	Pain	0	0	k	. REPRODUCTIVE/URINA	TION
Forearm	D	(E)	D	0	Ð	•	Discharge	0	0		Normal	Impotence
Hand Buttock	®	Œ	(B)	(H)	Œ	®	Other	0	0	H	Olnability To Hold Urine	
	B	B	B	(1)	B	B	FADO			6174 6	OPainful Urination	Other
Hip	(D)	B	(B)	(B)	®	B	e. EARS				Frequent Urination	
Thigh	0	0	0 6	0	0	0	ONormal Librarian Trans		t Left		Olrregular Menstruation	
Leg	0	0	0	0	0	0	Hearing Troub				Painful Menstruation	
1 001	Ð	D	D	D	Ð	(D)	Ringing	0	0		Abnormal Vaginal Blee	eding
2. Currently	/ VOU	r nair	ie ei	narav	atod	by	Pain	0	0		CLANDULAD	
Coughing		Pall		ygrav ⊃Liftin		Jy.	Discharge	0	0		GLANDULAR	-0-1
Sneezing	100			Bend			Other	0	0		Normal Heat/Cold Intolerance	Goiter
Straining	75	ool		Sittin			f. NOSE			THE STATE OF	Sugar In Urine	Other
Neck Mo				Stan	-		Normal				Cougar in onne	Other
Reaching				⊃ Walk				Absend	ce Of S	Smell	n. MENTAL	
Other					13			Other	010	ATTION II	Normal	O Phobias
							Colouing	000101		SIL	Anxiety	O Mood Swings
3. Since yo	ur sv	mpto	ms b	egan			g. MOUTH/THROAT				OPERTOR	Other
have you								○Absend	e Of T	aste	Memory Loss or Impai	
O Bowel Fr				Blade		nction	The same party and the same part	Abnorn			Cincillory Loss of Impai	THORIE THE PARTY OF THE PARTY O
			Erectio					Other				

2. What are your habits? Smoking (\$) (3) (5) Alcohol A A Recreational Drugs R CRO R 1 Exercise 1

PAIN DIAGRAMS

Please mark the location of your pain on these figures



1.	H	EALTH CARE	Yes	No
	a.	Have you been to a chiropractor	0	OD
	b.	Do you have a family physician	0	0
	C.	WOMEN:		
		To the best of your knowledge are you pregnant	0	OD
		Are you under the regular care of an OB-GYN	9	OD
	d.	Have you been hospitalized in the past five years	9	N
	e.	Are you currently taking any medication	0	OD
		Anti-inflammatory (Aspirin, Motrin, etc.)		

Muscle Relaxants

Pain Medication/Analgesic

Tranquilizers

OBirth Control Pills

. Which of the following	illnesses have you had?
○ No Previous Conditions/Illr	esses
○ Arthritis	○Ulcer
○ Asthma	Cancer
○Sinus Trouble	Polio
○Hay Fever	Rheumatic Fever
Allergies	Serious Injury
○ Tuberculosis	○Bone Fracture
Oliabetes	ODislocated Joints
Epilepsy	Spinal Disc Disease
Thyroid Trouble	Multiple Sclerosis
High Blood Pressure	Scoliosis
CLow Blood Pressure	Mental/Emotional Difficul
OHeart Trouble	Prostate Trouble
OHIV/ARC	○Kidney Trouble
OAIDS .	Other

3. FAMILY HISTORY

				/	/	/	13	0/	/	1	/	1	/	1	1	1	/	1/
			1	/	1	/	Unssen.	/	5/0	/	1	1	1	/	1	1	1	/
			1	History Tree	19/9	0	1	Science	1	B-CH Pres	lem	Jose Protemo	em	Pinritic obleme	/-	100	Banosis	1/8
		1	10	0/2	1948 46 S	9/	10	5	No dock	0	0	5/3	8	0/0	0/2	5/5	890,0818	Posture
	1	D'OCE	to offer	50	46	M. Ofe	dolla	/	000	3	5	S	20	Dining.	nched	60	000	3/
	/ci	10	12	12	15	1	/	12	/2	/00	10	1/5	V	10	10	0/6	100	
Father	Ð	Ð	Ð	Ð	Ð	Ð		Ð	Ð	(D)	Ð	Ð	D	Ð	D	D	D	
Mother	OM)	0	(10)	M	OD)	W		M	OD)	(M)	M	M	M	(1)	OD)	(M)	(M)	
Brothers	B	B	®	B	B	B		B	B	(B)	B	B	B	B	B	B	B	
Sisters				(3)		3		(5)	(3)	3	3	3	(3)	(\$)	(3)	(5)	3	
Children	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	

E.INSURANCE INFORMATION	Yes	No
Is your condition due to an automobile accident		
Date of Accident	•••	
Have You filed an accident report	•	N
2. Is your condition due to a job injury Date of Injury	O	Ø
Have You filed an injury report	. •	(N)
3. Do you have health insurance	①	(N)
Company Policy #		
4. Are you covered by 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:

OCash OCheck	OCredit (Card
○MasterCard	○ Visa	American Express
Account #		Exp. Date
All accounts not paid on your credit card.	within 90 day	s will automatically be put through
Patient's Signature		Date
Guardian or Spouse's S	ignature	Date
Doctor's Signature		Date

Sexually Transmitted Disease

AUTOMOBILE CRASH QUESTIONNAI		Pat	tient N	vame:		Particular Control	OF REAL PROPERTY.
ear Patient:		MO		YEAR	DR#	PATI	ENT NUMBER
his questionnaire will allow you to describe your automobile accident in detail.	Please			9			
emplete it carefully as the information provided will assist the doctor in evalual ocumenting your condition. THANK YOU.	ting and	00	0				
continuity your continuit. Tribute 100.		D B		10 1	1000	The second second	
		39		20 2			200000
se a No. 2 pencil to mark your answers. When marking in a	n Other	(D) (D)		303	1200	Total Principle	000000
ubble please explain in the space allowed. Fill in bubbles compl		O	(3)	40 (D)	D D G		
dicated here: . Erase changes cleanly. Do not fold form.	ciciy as	6 12	1	50 5	000	0000	00000
The state of the s			100	60 6	666	6000	00000
			20 3	10 O	DDa	DODO	DODDDD
			30 D	3D 3 D	333	0000	
VEHICLE YOU WERE IN				90 9		18'S 15'E	999999
Vehicle type? 2. Vehicle size?	d 101	hat de	12000	o did ti		le sustai	The state of the s
Car Pickup Subcompact Full-Size	U. VV	Minima	alliay	○ Mode	erate	C Extensi	ve Totaled
Van Truck Compact Mini		Unsure		Othe			, o o iotaloo
Station Wagon Bus Mid-Size Light		Ondar	,	0000			
Other Other	2 5000	and Va	hiclo	To Ste	ika Vahi	cle You W	lara In
Other	Halling Court of the Court of t						
Wile-A was a series in the series in the		hicle	type			Vehicle s	
What was your location in the vehicle?		Car			ickup	Subcon	
Oriver Front Passenger Rear Passenger				OT		Compac	
Passenger Location: Cleft Middle Right	C	Station	Wago	n OB	us	O Mid-Siz	e Clight
Other	C	Other				Other	
What was the vehicle you were in doing?							
Mark only ONE bubble below to answer this question	c. Ho	ow did	this	vehicle	e strike	he vehicl	e you were in?
a. Vehicle stopped for	Daniel Lance						Rear Ended
○ Traffic Light ○ Intersection ○ Stop Sign ○ Traffic						Sideswiped	
Pedestrian Parked	The state of the s	Other	when c	mign		Sideswiped	On Len
Other		Outer					
Other	1 100					F	•
L Mala Land Land						le sustair	
b. Vehicle slowing down for) Minima	al	O Mode	erate	Extension	ve O Totaled
○ Traffic Light ○ Intersection ○ Stop Sign ○ Traffic		Unsure	9	Othe	r		
Pedestrian Turning Parking							
Other Designation and the second seco	3. Desc	cribe C	Other	Vehicl	es To St	rike Vehic	le You Were In
THE RESERVE AND ASSESSMENT OF THE PARTY OF T	○ Ve	hicle Ty	pe:	SE VENT	C	How it struc	ok:
c. Vehicle moving	○ Ve	hicle Si	ze:		C	Damage:	
Slowly Moderately Fast				I HE HAD	71.00		distant in the second
MPH Accelerating	4. Were	traffi	c cita	tions i	ssued a	s a result	of the acciden
Other		Citatio					er Of Other Vehicle
				You We	ro In		Unsure
d. Vehicle doing other	Class	1001 01	vornore	TOU IVE	ic iii	_ 10u	Ouristire
Other	C CON	DITIC	NS	AT TI	ME OF	ACCIDE	NT
Couler			-	THE REAL PROPERTY.		AND THE PARTY OF T	
What damage did the vehicle you was in suctain?						lent occu	
What damage did the vehicle you were in sustain?		aylight		Dawn		Dusk	O Night
Minimal Moderate Extensive Totaled	00t	her	DATE:	DEFENS		10000000000000000000000000000000000000	
Other Other			D. SEE	e 7 e Mari	400 - 100		
E OTHER VEHICLES INVOLVED IN A COIDENT	2. What	t was	the c	onditio	n of the	road?	
F OTHER VEHICLES INVOLVED IN ACCIDENT	O Dr	у		O Dam	0 0	Wet	Snow Covered
First Vehicle To Strike Vehicle You Were In	O lcy	1		Othe	r		
a. Vehicle type? b. Vehicle size?							
Car Pickup Subcompact Full-Size	3. Visib	ility					
Van Truck Compact Mini		-	as the	visibi	lity at in	pact?	
Station Wagon Bus Mid-Size Light		Good		O Fair		Poor	
Other Other		Other		_ ran		, 001	
Conte		Outer		100			
	h if	vicibit	ida - sa-	00 000	r who		
c. How did this vahiola strike the vahiala var ware 1-0	2 2 2 2	VISIDII	ity W	CHICAGO CONTRACTOR	r, why?		
c. How did this vehicle strike the vehicle you were in?							
Head On From Right From Left Rear Ended	C				ness C	Rain	○ Snow
	C	Sun Lig Fog		O Darkı O Traffi		Rain	Snow

AT MOMENT OF IMPACT		b. Right Upper Ext		
1. Were you prepared for the accident?		Steering Wheel	 Dashboard 	Windshie
Accident A Complete Surprise	A PROBLEM STATE	Right Side Door	C Left Side Door	Armrest
Aware Of Impending Collision And Brad	ced For Impact	Right Window	C Left Window	Headrest
2 Foot On Broke Badal		○ Ceiling	Console	Shift Levi
2. Foot On Brake Pedal		Front Seat	Rear View Mirror	
a. Was your foot on brake pedal at impa	Ct / Yes No	Other		
b. Was it knocked off pedal by impact?	○ Yes ○ No	c. Left Upper Extre		STRIKE CO.
2 Use Of Bashe 1	President and Control	 Steering Wheel 	 Dashboard 	Windshie
3. Use Of Restraints		 Right Side Door 	 Left Side Door 	Armrest
a. Restraint Belts		Right Window	Left Window	Headrest
1. Were you wearing a restraint belt?	O Yes O No	Ceiling	Console	Shift Leve
O MILES AND	Riving Miles	Front Seat	Rear View Mirror	
2. What type of restraint belt were yo		Other	38 1 1 30 30 5	
Shoulder-Lap Belt Shoulder Belt	C Lap Belt	MACE TO PROPERTY		
		d. Torso		
b. Headrests	et model A	Steering Wheel	Dashboard	Windshie
1. Was vehicle equipped with headre	sts? Yes No	 Right Side Door 	C Left Side Door	Armrest
CAN AND AND AND AND AND AND AND AND AND A		Right Window	C Left Window	Headrest
2. What position was the headrest in		Ceiling Ceiling	○ Console	Shift Lev
C Low Middle High	O Don't Know	Front Seat	Rear View Mirror	Mark Dalling
	THOUSE THE PARTY OF THE PARTY O	Other		
c. Air Bags		n domp?	Stary pay aluste i	
1. Was vehicle equipped with air bag	s?	e. Right Lower Ext	remity (Leg)	
Yes No Unsure	Chiana Calland III	Steering Wheel	Dashboard	○ Windshie
to the management of the matter	and Comments of	Right Side Door	Left Side Door	Armrest
2. Did the air bags deploy?	○ Yes ○ No	Right Window	Left Window	Headrest
		Ceiling	Console	Shift Lev
4. Your Body		Front Seat	 Rear View Mirror 	
a. What was your body position at impa		Other	Tel awa's may	
 Straight Slouched Forward Rotated 	: Right Left	ert die Englische von		
On't Recall Other		f. Left Lower Extre	mity (Leg)	
The Villagens Shin Value of Street	3 Describe O	Steering Wheel	Dashboard	Windshie
b. What direction was your body throw		Right Side Door	C Left Side Door	Armrest
Forward\Backward Backward\Forward	DESCRIPTION OF THE PROPERTY OF	 Right Window 	C Left Window	Headrest
Across Vehicle Outside Vehicle		Ceiling Ceiling	Console	Shift Leve
Obn't Recall Other	arraw eroty A		Rear View Mirror	
5. Your Head And Neck	APRIGATE SPECIA	Other		A VOUID
a. What position were your head/neck in		Did your body stril	re any other chica	ts?
Straight Tilted Forward Rotated		Description Of Other		
Opon't Recall Other		O Description Of Other	objects rout body Hit:	
Obout Nevall O'duet Market Neval N	18allowin -	Telegrapa of second	oy state or early are	
b. Through what motion were your head	/neck pitched?	STATE OF THE PARTY OF		
Forward\Backward Backward\Forward				
Opon't Recall Other Other	Language S			
	NEW TOTAL			
BESULT OF IMPACT	A VARIABLE WILLIAM CANT	DDITIONAL INF		
RESULT OF IMPACT 1. Which objects in the vehicle did the force	on of the	Additional Information Ab		cident:
collision cause your body to strike?		Compact Compact	4804	THE STATE OF THE S
a. Head		STATE OF STREET		
Steering Wheel Dashboard	Windshield			
	Armrest			
	COLUMN AND AND ADDRESS OF	erdw way starday s		
		and trail and the state		
	The state of the s			
Front Seat Rear View Mirror Other		Service estimate		

ACCIDENT /			The second		tient N		mm II	gra a spin-		10.55
ear Patient:				МО	DAY	YEAR	DR#	PATI	ENT NUM	MBER
		tomobile accident in detail assist the doctor in evalua		00	0	0		0000		
cumenting your condition		assist the doctor in evalua	ating and	28				0000		
				39	FZ 98	20 2		000		
				4 1		30 3		0000		
se a No. 2 pencil to	mark your answers	. When marking in a	an Other	3 (D)		40 4	B. H			
ibble please explain i	n the space allowed.	Fill in bubbles comp	letely as	(E) (I)		30 (3)				
dicated here: . E	rase changes cleanl	y. Do not fold form.		(D) (D)	10 D			0000		
								000		
					20 3		CIRC MANAGEMENT	0000		
ATE AND TIME	OF ACCIDENT	/ INJURY	AND THE PROPERTY.		30 9		Bearing 1998	333		
			A If the	. ro 1110	-	90 (9)		9990		
Date:	Time:	: am/pm			ere lac		ns (cuts)			
ESCRIPTION C	E ACCIDENT / I	NJURY	O H				Should	ters		Buttocks
		A DATE OF THE PARTY OF THE PART	O No		***		Arms		® (D)	1 0040-0
	tionnaire Marked (Skip S	ection B)			1id Back		© Elbow			Thighs
Workmen's Compensati	A HONDY TANAHOSI ASSOCIATION STREET, SAN AND S			wer Ba	ick		D Forear	ms		
STANDARD STANDARDS STANDARDS	Pedestrian Accident		O Pe			-	Wrists		BD	
er: Accident	O Injury		THE RESERVE		ib Cage	d	Hands			Ankles
What was the cour	se of your accident	/injun/2		odomen					B D	Feet
	e or your accident	i injury f	00	ther						
0		manufacture la	E Daniel	wile a		har -!	an Missert	Indus		
			o. Desc	cribe a	any or	ner si	gnificant	injury:		
	BEET BUILDINGS IN	190 / 190 / 190								
			6. Eme	rgenc	y Car	e At A	ccident/In	njury Site)	
			a. Di	d you	recei	ve em	ergency	care?	○ Yes	ON
Describe in your o	wn words what hap	ppened:								
		The section is a little of the	b. W	hat ty	pe of	emerg	gency car	e did you	u receiv	ve?
		never the				Splin		Brace		ck Collar
			C	Other						
		THE STREET STREET	7. Dest	inatio	n Afte	r Acci	ident / Inj	ury		
			a. W	here o	did yo	u go?	b. By	whom w	ere yo	u drive
			-	Hospit	tal	O Hom	ie O	Myself	O Am	bulance
		Favarage Court Service	C	Schoo	ol	O Work		Friend	○ Far	nily Mer
		- aranamaan i		Other			0	Other		
								South Sain	MARKET ST	
		Sage of the United	D. HOS	PITAL	<u>L VIS</u>	IT AF	FTER A	CCIDEN	IT / IN.	JURY
	Andreal Andrew Co.		1. Whe	n did	you q	o to th	ne hospita	al?		
MEDIATELY A	FTER ACCIDEN	T/INJURY	O Irr	mediate	ely	⊃ Late	r That Day	Next Da	av O	Days La
Did you lose cons	ciousness?		O Da	ate	1		1000	Other		
O Yes O		now	1	HERE			SERVICE TO			
			OH	ospital N	Vame:			Examine	ed By Do	ctor:
How did you feel?				The state of				MANAGET IN II		Service of a
	Dazed Oizzy	Nervous							En la de	
	Other	O 1401 4003	Admit	ted:	Yes	No	O Dato F	ischarged:	1	
_ vvoun	ward!	STATE VALUE OF	Admit	iou. O	103	140	O Date L	nsonarged.		
Where did you imr	mediately develop	nain?	2 If v.	ave w	oro to	ken o	of what bo	ndy part/	612	
sample and Ann Hill				-	ere ta					Dutte -1
	® © Shoulders	® Buttocks	O He				Should	iers		Buttocks
Head	® Arms	⊕ ⊕ Hips	O No		1000		Arms		® D	Company of the
○ Head○ Neck	NEWAY:	® Thighs	OU	oper / M	1id Back		Elbow		(R) (D)	
Head Neck Upper / Mid Back	® © Elbows						D Torear	ms	(D)	Vnnnn
Head Neck Upper / Mid Back Lower Back	® © Forearms	® © Knees	O Lo	wer Ba	ck					
Head Neck Upper / Mid Back Lower Back Pelvis	® © Forearms ® © Wrists	® © Knees ® © Legs	○ Lo	elvis		d	Wrists		® D	Legs
HeadNeckUpper / Mid Back	® © Forearms	® © Knees	○ Lo	elvis	ck ib Cage	d			® D	
Head Neck Upper / Mid Back Lower Back Pelvis	® © Forearms ® © Wrists	® © Knees ® © Legs	LoPeCl	elvis	ib Cage	d	Wrists		® D	Legs Ankles

and and all the state of the st	vas performed, of wh Upper / Mid Back Lower Back	et body part(s)? Chest / Rib Cage Abdomen	k. Elbows Strain Fracture Other	Sprain Lacerations	® Disloc © Contu
4. If a MRI was pe Head Neck	erformed, of what boo Upper / Mid Back Lower Back	iy part(s)? Chest / Rib Cage Abdomen	I. Forearms	Sprain Lacerations	® © Disloca
Other		The Control of the Co	m. Wrists	- The State of the Party of the	
5. What was the o	liagnosis given at the	hosnital?	R Strain	Coroin	A Dislace
a. Head	nagnoolo given at the	, nospitar i	® © Fracture	Sprain D Lacerations	Disloca Contus
ConcussionContusions	Skull Fracture Other	Lacerations	® Other		
		The season of th	n. Hands / Fingers		
b. Jaw	avenue e		® © Strain	® © Sprain	® Disloca
Strain	Sprain	Dislocation	The Fracture		® © Contus
FractureContusions	Other	 Lacerations 	® Other	GANE A TREATMENT OF THE	
		non/sus.c 3 /	o. Buttocks		
c. Neck		The property of the last	® © Strain	® © Sprain	® ⊕ Lacerat
StrainFracture	SprainWhiplash	Dislocation Disc Injury	® Contusions	® Other	
 Lacerations 	Contusions		p. Hips		
Other			® © Strain	® Sprain	® Disloca
	MID 22/7		® © Fracture		® Contusi
d. Upper / Midd		Charlette (1834)	® © Other		
○ Strain	O Sprain	Dislocation	The state of the s		
Fracture Controlors	Other	 Lacerations 	q. Thighs		200
Contusions	Other		Strain Fracture	Sprain	® © Disloca
e. Lower Back	- Personal Programme and Company of the Company of	SEAST DESCRIPTION OF THE PROPERTY OF THE PROPE	® © Fracture		® © Contusi
Strain	Sprain	 Dislocation 	a contor		
Fracture	O Disc Injury	Lacerations	r. Knees		
Contusions	Other Other	A Richard Mark	® Strain	® © Sprain	® Dislocat
Editor Blanch	TEMBUS MENS	I gradustry i i i i	⊕	® © Lacerations	® Contusi
f. Pelvis			® © Other		
O Strain	○ Sprain	 Dislocation 			
Officer Officer	 Lacerations 	 Contusions 	s. Legs		
Other			® Strain	® Sprain	® Dislocat
g. Chest / Rib (Cage		R C Other	R C Lacerations	® © Contusi
Strain	○ Sprain	 Dislocation 	TO CHIEF	- Saystivios may	Market Epoca
Fracture	 Lacerations 	Contusions	t. Ankles	Carlo Carlo agentino	
Other		E Carlos Company Constitution of the Constitut	® Strain	® © Sprain	⊕ Dislocat
				® © Lacerations	® Contusi
h. Abdomen			® ⊕ Other		Haralet en en en
O Strain	 Lacerations 	Contusions		a service t	Juesanin
Other			u. Feet / Toes		
i Chaulden	CONTRACTOR OF SHAPE	V. HINNEY PERMITS	® C Strain	® © Sprain	® Dislocat
i. Shoulders	O = Court	O O Distracti	® © Fracture		® Contusi
Strain Fracture	Sprain Sprain	® © Dislocation	® © Other	2 12 12 12 12 12 12 12 12 12 12 12 12 12	10.20
® © Other		® Contusions	v. Other	MERSON PROMISE AND	
Other _	or a sequential and a sequential	70.1gs/0.1ss	O Strain	Sprain	 Dislocation
j. Arms		Walio Balance	Fracture	Sprain Lacerations	OlsiocationContusions
® Strain	® © Sprain	® Dislocation	Criadiais	_ Lavorations	Odifications
® Practure	® © Lacerations	® Contusions	w. Describe any ac	dditional diagnosi	s given:
		TO THE PERSON NAMED IN COLUMN			

D. HOSPITAL VISIT AFTER ACCIDENT / INJURY	i. Shoulders
6. What treatment was administered at the hospital?	
Oral Medication Sutures Splint Collar	® © Other
○ Injection	A SERVICE OF THE PROPERTY OF T
Topical Antiseptics Hot Packs Brace Surgery	j. Arms
Bandages Other	Pain ® Stiffness ® Numbness ® Tingling
	® Other
7. Instructions Given When Discharged From Hospital	Mana A Bartier (A) A The Company of the Company o
a. Were you told to see?	k. Elbows
General Practitioner Chiropractor Neurologist	Pain D Stiffness D Numbness D Tingling
Physical Therapist	® Other
General Surgeon Plastic Surgeon	· · · · · · · · · · · · · · · · · · ·
Other	I. Forearms
b 14th -4	Pain Stiffness Numbness Tingling
b. What recommendations were made?	® D Other
No Further Care No Follow-up Instructions Observation	m. Wrists
Rest Ice Heat Collar Support	
Offine Off Work Outlet	Pain Pain Numbness Numbness Other
c. Were medications prescribed?	C Other
Pain Anti-inflammatory Antibiotic Nervousness	n. Hands / Fingers
Other	Pain Pain Numbness Tingling
O VIII	® Other
. FOLLOWING THE ACCIDENT / INJURY	a como
How much later did additional symptoms develop?	o. Buttocks
Immediately Hours That Evening Next Morning	Pain C Stiffness Numbness C Tingling
O Days Week O Month	® ○ Other
2. What additional symptoms developed?	p. Hips
a. Head Consenses and he was bortung making	Pain Stiffness Numbness D Tingling
Pain Stiffness Numbness Tingling	® © Other
Other	
	q. Thighs
b. Jaw	▶ □ Pain
Pain Stiffness Numbness Tingling	® ○ Other
Other	r. Knees
c. Neck	Pain Pain Numbness D Tingling
Pain Stiffness Númbness Tingling	® O Other
Other Other	
subseque)	s. Legs
d. Upper / Middle Back	Pain Pain Stiffness Numbness Tingling
Pain Stiffness Numbness Tingling	® □ Other
Other	
	t. Ankles
e. Lower Back	Pain Pain Numbness D Tingling
Pain Stiffness Numbness Tingling	® O Other
Other	
	u. Feet / Toes
f. Pelvis	Pain C Stiffness Numbness D Tingling
Pain Stiffness Numbness Tingling	© Other
Other	
The state of the s	v. Other O
g. Chest / Rib Cage	0.01
	3. Since your accident / injury have you suffered from?
Other	Blurred Vision Chest Pain Nausea
h. Abdomen	O Double Vision O Difficulty Breathing O Vomiting
	Reduced Vision Palpitations Frequent Urination
Pain Stiffness Numbness Tingling Other	O Impaired Hearing Constipation Inability To Hold Urine
Ottle	 Ringing In Ears Diarrhea Painful Urination

4. Additionally have you experienced any of the following?	Diagnosis And Treatment Recommendation:
Anxiety Convulsions Restlessness	Diagnosis And Treatment Accommendation.
Oppression Dizziness Insomnia	Tallet St. Wallet St. Stephen
Nervousness Fainting Reduced Appetite	
Poor Memory Loss Of Balance Weakness	
Tension Fatigue Weight Gain	g. Plastic Surgeon Name:
Other	Diagnosis And Treatment Recommendation:
. Are you restricted in any of the following areas as a	
result of this accident/injury?	The state of the s
Daily Living Occupational/Work Recreational Activities Other	
Other	h. Psychologist O Name:
6. Have you missed work due to this accident / injury?	O Diagnosis And Treatment Recommendation:
Missed No Work Limited Work Activity	
Missed Work From: To:	
Other	
7. Did you self treat your symptoms?	Segmental of the lead Mark the graph september 1911
Over-The-Counter Medication	i. Other Name: Type:
Other	
. Did you seek medical care elsewhere?	Diagnosis And Treatment Recommendation:
a. General Practitioner Name:	The state of the s
O Diagnosis And Treatment Recommendation:	
	The state of the science state of the state
	9. Have you had any of the following tests?
	CT Scan MRI Electrodiagnostic Studies
	Othor
b. Internist Name:	Other
b. Internist Name: Diagnosis And Treatment Recommendation:	
	10. What is the reason for seeking today's consultat Persisting Complaints Worsening Of Symptoms
	10. What is the reason for seeking today's consultat
O Diagnosis And Treatment Recommendation:	10. What is the reason for seeking today's consultat Persisting Complaints Worsening Of Symptoms
O Diagnosis And Treatment Recommendation:	10. What is the reason for seeking today's consultated Persisting Complaints Worsening Of Symptoms Other F. INSURANCE / ATTORNEY INFORMATION 1. Have you contacted an insurance adjuster Yes
Diagnosis And Treatment Recommendation: C. Chiropractor Name:	10. What is the reason for seeking today's consultat Persisting Complaints Other F. INSURANCE / ATTORNEY INFORMATION
O Diagnosis And Treatment Recommendation:	10. What is the reason for seeking today's consultated Persisting Complaints Worsening Of Symptoms Other F. INSURANCE / ATTORNEY INFORMATION 1. Have you contacted an insurance adjuster Yes
Diagnosis And Treatment Recommendation: c. Chiropractor	10. What is the reason for seeking today's consultated Persisting Complaints Worsening Of Symptoms Other F. INSURANCE / ATTORNEY INFORMATION 1. Have you contacted an insurance adjuster or representative regarding this claim?
C. Chiropractor Name:	10. What is the reason for seeking today's consultated Persisting Complaints Worsening Of Symptoms Other F. INSURANCE / ATTORNEY INFORMATION 1. Have you contacted an insurance adjuster or representative regarding this claim? Company:
C. Chiropractor Name:	10. What is the reason for seeking today's consultated Persisting Complaints Worsening Of Symptoms Other F. INSURANCE / ATTORNEY INFORMATION 1. Have you contacted an insurance adjuster or representative regarding this claim? Company: Adjuster: Claim #:
C. Chiropractor Name: Diagnosis And Treatment Recommendation:	10. What is the reason for seeking today's consultated Persisting Complaints Worsening Of Symptoms Other F. INSURANCE / ATTORNEY INFORMATION 1. Have you contacted an insurance adjuster or representative regarding this claim? Company: Adjuster: Claim #:
c. Chiropractor Name: Diagnosis And Treatment Recommendation: d. Neurologist Name:	10. What is the reason for seeking today's consultated Persisting Complaints Worsening Of Symptoms Other F. INSURANCE / ATTORNEY INFORMATION 1. Have you contacted an insurance adjuster or representative regarding this claim? Company: Adjuster: Claim #:
C. Chiropractor Name: Diagnosis And Treatment Recommendation:	10. What is the reason for seeking today's consultated Persisting Complaints Worsening Of Symptoms Other F. INSURANCE / ATTORNEY INFORMATION 1. Have you contacted an insurance adjuster or representative regarding this claim? Company: Adjuster: Claim #:
C. Chiropractor Name: Diagnosis And Treatment Recommendation: Diagnosis And Treatment Recommendation:	10. What is the reason for seeking today's consultated Persisting Complaints Worsening Of Symptoms Other F. INSURANCE / ATTORNEY INFORMATION 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:
C. Chiropractor Name: Diagnosis And Treatment Recommendation: Diagnosis And Treatment Recommendation: d. Neurologist Name:	10. What is the reason for seeking today's consultate Persisting Complaints Worsening Of Symptoms Other F. INSURANCE / ATTORNEY INFORMATION 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:
C. Chiropractor Name: Diagnosis And Treatment Recommendation: Diagnosis And Treatment Recommendation:	10. What is the reason for seeking today's consultated Persisting Complaints Worsening Of Symptoms Other F. INSURANCE / ATTORNEY INFORMATION 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:
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C. Chiropractor Name: Diagnosis And Treatment Recommendation: Diagnosis And Treatment Recommendation: d. Neurologist Name: Diagnosis And Treatment Recommendation: e. Orthopedist Name:	10. What is the reason for seeking today's consultated Persisting Complaints Worsening Of Symptoms Other F. INSURANCE / ATTORNEY INFORMATION 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?
C. Chiropractor Name: Diagnosis And Treatment Recommendation: Diagnosis And Treatment Recommendation: d. Neurologist Name: Diagnosis And Treatment Recommendation: e. Orthopedist Name:	10. What is the reason for seeking today's consultated Persisting Complaints Worsening Of Symptoms Other F. INSURANCE / ATTORNEY INFORMATION 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?
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