

CONFIDENTIAL PATIENT INFORMATION

DATE ____/____/____

PLEASE PRINT**PATIENT INFORMATION:**

FULL NAME _____ DATE OF BIRTH ____/____/____ AGE ____ Male ☐ Female ☐
ADDRESS _____ APT# _____ SSN ____ - ____ - ____
CITY _____ STATE _____ ZIP CODE _____ HOME PHONE (____) _____
ALTERNATE PHONE (CELL): (____) _____ EMAIL ADDRESS: _____
EMPLOYER'S NAME _____ OCCUPATION _____
WORK ADDRESS _____ CITY _____ STATE _____ ZIP _____
WORK PH. # (____) _____ EXT. _____ DATE SYMPTOMS BEGAN: ____/____/____
MARITAL STATUS: SINGLE ☐ MARRIED ☐ WIDOWED ☐ HOW DID YOU HEAR ABOUT US? _____
EMERGENCY CONTACT _____ PHONE _____

CLAIM INFORMATION:

IS YOUR CONDITION DUE TO AN AUTO ACCIDENT ☐ A PERSONAL INJURY ☐ A WORK INJURY ☐ OTHER ☐
TYPE OF CLAIM: CASH ☐ GROUP HEALTH INS ☐ PERSONAL INJURY ☐ WORKER'S COMP ☐ MEDICARE ☐
I WILL BE PAYING TODAY BY CASH ☐ CHECK ☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DISCOVER ☐ OTHER ☐

INSURANCE INFORMATION:

RELATIONSHIP TO INSURED? SELF ☐ SPOUSE ☐ OTHER ☐ CHILD ☐ SPOUSE: _____
INSURED'S EMPLOYER SAME AS ABOVE ☐ _____
INSURED'S SSN SAME AS ABOVE ☐ SSN ____ - ____ - ____ INSURED'S DOB SAME AS ABOVE ☐ ____/____/____
PRIMARY INSURANCE CO. _____ ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____ PHONE#(____) _____
POLICY NUMBER _____ GROUP NUMBER _____

SECONDARY INSURANCE CO. _____ ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____ PHONE#(____) _____
POLICY NUMBER _____ GROUP NUMBER _____

AUTHORIZATIONS:

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.
B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.
C. 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 products or professional services rendered will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

VERIFICATION OF INSURANCE BENEFITS

IF GROUP INSURANCE: Is there coverage for Chiropractic Care? YES ☐ NO ☐ DATE ____/____/____

Plan Administered by _____

Is Doctor In Network ☐ Out of Network ☐

Pre-Authorization Required? ? YES ☐ NO ☐

IN NETWORK BENEFITS

Amount of Deductible:\$_____/Individual \$_____/Family

Deductible met? YES ☐ NO ☐ \$____ Remaining

Deductible **Calendar** ☐ or **Fiscal** ☐ Renewal Date ____/____/____

Max. Yearly Benefit ? \$____ Co-pay \$____ % Coverage ____

Max. Yearly Visit Limit? _____

Orthotics Coverage (CPT Code: L3030)? YES ☐ NO ☐ \$____

Exclusions/Limitations: _____

Notes: _____

Spoke to Whom? _____

Direct Telephone: _____

OUT OF NETWORK BENEFITS

Amount of Deductible:\$_____/Individual \$_____/Family

Deductible met? YES ☐ NO ☐ \$____ Remaining

Deductible **Calendar** ☐ or **Fiscal** ☐ Renewal Date ____/____/____

Max. Yearly Benefit ? \$____ Co-pay \$____ % Coverage ____

Max. Yearly Visit Limit? _____

Orthotics Coverage (CPT Code: L3030)? YES ☐ NO ☐ \$____

Exclusions/Limitations: _____

IF AUTO ACCIDENT

Who was found at fault / ticketed **Patient** ☐ **Other Driver** ☐

Insured Auto Insurance Carrier. _____ Address _____

City _____ State _____ ZIP Code _____ Phone#(____) _____

POLICY NUMBER _____ CLAIM NUMBER _____

Adjuster for the Claim? _____ Coverage Verified? _____

Deductible Amount? \$ _____ Spoke to Whom? _____

Does your auto insurance coverage have **Medical Payments** Coverage? YES ☐ NO ☐

If yes, Auto Insurance Carrier. _____ Address _____

City _____ State _____ ZIP Code _____ Phone#(____) _____

POLICY NUMBER _____ CLAIM NUMBER _____

Adjuster for the Claim? _____ Coverage Verified? _____

Deductible Amount? \$ _____ Spoke to Whom? _____

ATTORNEY'S NAME _____ PHONE#(____) _____

IF WORKER'S COMPENSATION:

Employer's Name _____ Employer's #(____) _____

Employer's Address: _____ Is patient Currently Employed at Same? _____

Has the injury been reported? YES ☐ NO ☐ Has care been authorized? ? YES ☐ NO ☐ By whom? _____

Employer's Insurance Carrier. _____ Address _____

City _____ State _____ ZIP Code _____ Phone#(____) _____

POLICY NUMBER _____ GROUP NUMBER _____

HEALTH QUESTIONNAIRE

Initial Re-Eval

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. PATIENT INFORMATION

Marital Status:

Sex:

Patient Lives With:

- ☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed

☐ M ☐ F

Children:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

- ☐ Alone
☐ Spouse
☐ Children
☐ Other
☐ Parents
☐ Roommate(s)
☐ Assisted Living

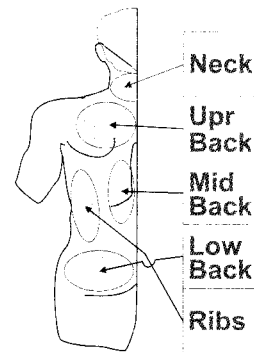
Patient Name:

MO	DAY	YEAR	DR#	PATIENT NUMBER
1	2	1	0	0
2	3	2	1	1
3	4	3	2	2
4	5	4	3	3
5	6	5	4	4
6	7	6	5	5
7	8	7	6	6
8	9	8	7	7
9	0	9	8	8

B. PATIENT'S COMPLAINTS

1. Mark Your Present Complaints Below ☐ Physical Examination with no complaints

Neck / Back



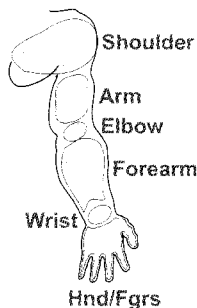
		Same As Left	Pain	Numbness	Tingling	Stiffness	Soreness	Swelling	Weakness	Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Aching	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved
Neck	Left	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Right	S	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U
Upr Back	Left	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Right	S	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U
Mid Back	Left	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Right	S	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U
Low Back	Left	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Right	S	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U
Ribs	Left	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Right	S	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U

When Did Your Neck/Back Complaints Begin?

☐ Date:

____/____/____

Upper Extremities



		Same As Above	Pain	Numbness	Tingling	Stiffness	Soreness	Swelling	Weakness	Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Aching	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved	
L	Shoulder	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R	
	Arm	S	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Elbow	S	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Forearm	S	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Wrist	S	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Hnd/Fgrs	S	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
R	Shoulder	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R	
	Arm	S	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Elbow	S	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Forearm	S	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Wrist	S	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Hnd/Fgrs	S	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R

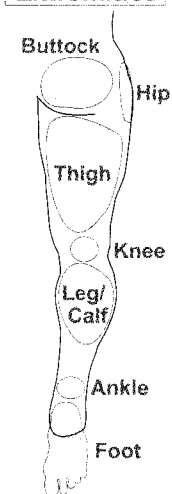
When Did Your Upper Extremity Complaints Begin?

☐ Same Date As Neck/Back

☐ Different Date:

____/____/____

Lower Extremities



		Same As Above	Pain	Numbness	Tingling	Stiffness	Soreness	Swelling	Weakness	Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Aching	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved	
L	Hip	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R	
	Buttock	S	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Thigh	S	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Knee	S	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Leg/Calf	S	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Ankle	S	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
R	Hip	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R	
	Buttock	S	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Thigh	S	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Knee	S	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Leg/Calf	S	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Ankle	S	P	N	T	S	S	S	W		M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R

When Did Your Lower Extremity Complaints Begin?

☐ Same Date As Neck/Back

☐ Different Date:

____/____/____

B. PATIENT'S COMPLAINTS (CONTINUED)

2. How Did Your Complaint(s) Begin[1]?

☐ Unknown ☐ Suddenly ☐ Gradually

3. What Happened To Cause Or Re-Aggravate Your Complaint(s)?

☐ Cause Not Known ☐ Auto Accident
☐ Work Accident/Injury ☐ Home Accident
☐ Personal Injury ☐ Sport Injury

☐ Other - Describe: _____

4. How Would You Rate Your Overall Pain Today Where 0 Is No Pain And 10 Is The Worst Pain[1]?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible

5. When Are Your Symptoms Worse?

☐ Morning ☐ Afternoon ☐ Evening ☐ Night
☐ Always The Same

6. What Makes Your Condition Better?

☐ Nothing ☐ Stretching ☐ Heat
☐ Rest ☐ Exercise ☐ Ice
☐ Sitting ☐ Standing ☐ Medications
☐ Other

7. What Makes Your Condition Worse?

☐ Nothing ☐ Coughing ☐ Reaching ☐ Standing
☐ Sneezing ☐ Lifting ☐ Sitting ☐ Pulling
☐ Bending ☐ Walking ☐ Straining at Stool ☐ Turning
☐ Other

8. Have Any Of Your Complaint(s) Existed In The Past? ☐ Yes ☐ No

If Yes, Indicate Below

☐ Neck ☐ Upr Back ☐ Mid Back ☐ Low Back ☐ Ribs
☐ Shoulder ☐ Arm ☐ Elbow ☐ Forearm ☐ Wrist ☐ Hnd/fgrs
☐ Buttock ☐ Hip ☐ Thigh ☐ Knee ☐ Leg/calf ☐ Ankle
☐ Foot ☐ Others:

9. Have You Had Any Recent Treatment For Your Conditions OUTSIDE Of This Office[1]?

☐ Yes ☐ No If Yes, List Dates, Treatments, And Doctors.

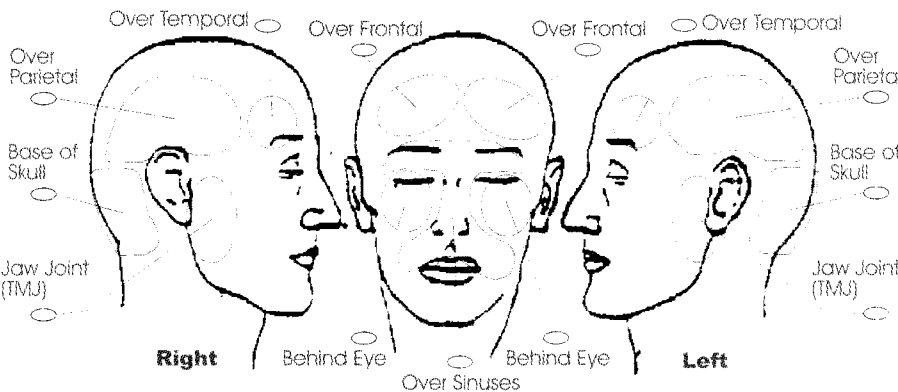
10. Since Your Symptoms Began, Have You Noticed A Change In?

Bowel Function ☐ Yes ☐ No
Bladder Function ☐ Yes ☐ No ☐ No To All
Sexual Function ☐ Yes ☐ No

C. HEADACHES

If You Are Experiencing Headaches, Please Fill Out This Section Otherwise Skip To Section D.

1. Where is The Pain Associated With Your Headaches Located?



6. What Seems To Bring On Your Headaches?

☐ Physical Activity ☐ Caffeine
☐ Excessive Stress ☐ Certain Foods
☐ Alcohol ☐ Menstrual Period
☐ Other

7. How Often Do They Occur[1]?

Times/Week: 1 2 3 4 5 6 7 8 9
Times/Month: 1 2 3 4 5 6 7 8 9
☐ Other

8. How Long Do Your Headaches Last[1]?

☐ Less Than 1 Hour ☐ From 1-3 Hours
☐ Longer Than 3 Hours ☐ All Waking Hours
☐ Several Hours To Days
☐ Other

2. On What Date Did Your Headaches Begin[1]?

Date: / / ☐ Same As Neck/Back Complaints

3. How Does The Intensity Of Your Headaches Rate[1]?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible

4. What Describes Your Pain?

☐ Dull ☐ Sharp ☐ Aching ☐ Stabbing
☐ Deep ☐ Vice-Like ☐ Burning ☐ Throbbing/Pulsating
☐ Other

5. When Do Your Headaches Usually Start?

☐ Constant/Anytime Awake ☐ Wake Up With In Morning
☐ At Midday ☐ During Evening

9. Do Your Headaches Wake You From Sleep[1]?

☐ No ☐ Sometimes ☐ Always

10. Do Any Of The Following Occur With Your Headaches?

☐ Nausea/Vomiting ☐ Weakness
☐ Tremor ☐ Vision Problems
☐ Dizziness ☐ Light/Sound Sensitivity
☐ Other

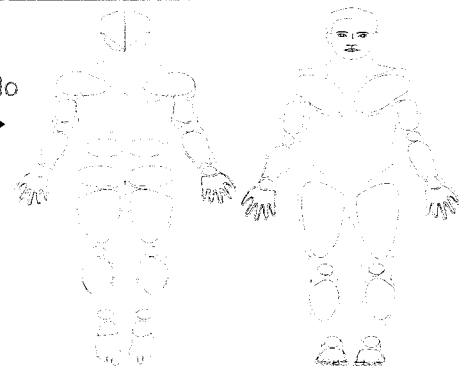
11. What Makes Your Headaches Better?

☐ Nothing ☐ Rest ☐ Lying Down ☐ Ice/Cold Packs
☐ Massage ☐ Standing ☐ NSAIDS (Aspirin, Tylenol, etc.)
☐ Other

D. OTHER COMPLAINTS

Do you have any other complaints not covered on this form[1]? ☐ Yes ☐ No

If Yes, Describe other complaints in detail and mark body areas on Figures. →



HEALTH QUESTIONNAIRE-HISTORY

Patient's Name _____

E. REVIEW OF SYSTEMS

Are You Currently Suffering From Any Of The Symptoms Listed Below? If This Is A Re-Examination Mark Only New Symptoms Since Your Last Exam.

☐ None Of The Symptoms Listed Below ☐ No New Symptoms Since Your Last Exam

- | | |
|---|--|
| <input type="radio"/> General Fatigue | <input type="radio"/> Skin Rash |
| <input type="radio"/> Weakness | <input type="radio"/> Redness Of Skin |
| <input type="radio"/> Fever (continuous) | <input type="radio"/> Skin Itching |
| <input type="radio"/> Loss Of Sleep | <input type="radio"/> Skin Dryness |
| <input type="radio"/> Chills (continuous) | <input type="radio"/> Eczema(red, inflamed skin) |
| <input type="radio"/> Weight Change (unplanned) | <input type="radio"/> Hair Changes (unplanned) |
| <input type="radio"/> Night Sweats | <input type="radio"/> Nail Changes (unplanned) |
| <input type="radio"/> Headaches | <input type="radio"/> Bruise Easily |
| <input type="radio"/> Dizziness | <input type="radio"/> Cough (chronic) |
| <input type="radio"/> Fainting | <input type="radio"/> Wheezing (chronic) |
| <input type="radio"/> Convulsions | <input type="radio"/> Difficulty Breathing |
| <input type="radio"/> Nervousness | <input type="radio"/> Swollen Extremities |
| <input type="radio"/> Anxiety | <input type="radio"/> Blue Extremities |
| <input type="radio"/> Depression (prolonged) | <input type="radio"/> Varicosities (visible veins) |
| <input type="radio"/> Phobias (excessive fears) | <input type="radio"/> Rapid Heart Beat |
| <input type="radio"/> Memory Loss Or Impairment | <input type="radio"/> Chest Pain |
| <input type="radio"/> Mood Swings (excessive) | <input type="radio"/> Heart Palpitations |
| | <input type="radio"/> Heart Murmur |
| <input type="radio"/> Hearing Trouble | <input type="radio"/> Decreased Appetite |
| <input type="radio"/> Ringing in Ears | <input type="radio"/> Increased Appetite |
| <input type="radio"/> Pain in Ears | <input type="radio"/> Abdominal Pain |
| <input type="radio"/> Ear Discharge | <input type="radio"/> Hemorrhoids |
| <input type="radio"/> Vision Trouble | <input type="radio"/> Excess Gas |
| <input type="radio"/> Pain in Eyes | <input type="radio"/> Vomiting (excessive) |
| <input type="radio"/> Eye Discharge | <input type="radio"/> Diarrhea (excessive) |
| <input type="radio"/> Nose/Sinus Pain | <input type="radio"/> Constipation (excessive) |
| <input type="radio"/> Excessive Drainage | <input type="radio"/> Heartburn/Indigestion |
| <input type="radio"/> Nose Bleeds (chronic) | <input type="radio"/> Painful Urination |
| <input type="radio"/> Nasal Infections (chronic) | <input type="radio"/> Inability To Hold Urine |
| <input type="radio"/> Absence Of Smell | <input type="radio"/> Frequent Urination |
| <input type="radio"/> Mouth Sores | <input type="radio"/> Urinary Retention |
| <input type="radio"/> Bleeding Gums | <input type="radio"/> Bed-wetting |
| <input type="radio"/> Enlarged Glands | <input type="radio"/> Irregular Menstruation |
| <input type="radio"/> Absence Of Taste | <input type="radio"/> Painful Menstruation |
| <input type="radio"/> Abnormal Taste Sensation | <input type="radio"/> Abnormal Vaginal Bleeding |
| <input type="radio"/> Tonsillitis/Infected Tonsils | <input type="radio"/> Sterility |
| <input type="radio"/> Difficulty With Swallowing | <input type="radio"/> Impotence |
| <input type="radio"/> Heat/Cold Intolerance | <input type="radio"/> Lumps In Breast(s) |
| <input type="radio"/> Sugar In Urine | <input type="radio"/> Redness/Itching of Breast |
| <input type="radio"/> Goiter (enlarged Thyroid gland) | <input type="radio"/> Dimpling of Breast(s) |
| <input type="radio"/> Tremor (shaking) | <input type="radio"/> Discharge from Breast(s) |
| <input type="radio"/> Other (Please Describe) | <input type="radio"/> Breast Pain |

F. HABITS/ACTIVITIES

What Are Your Current Habits? Packs Per Day
Smoking..... ☐ Never ☐ <1 ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ 5+

Glasses Per Day
Caffeinated Drinks..... ☐ Never ☐ <1 ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ 5+

Glasses Per Day
Alcohol Consumption..... ☐ Never ☐ <1 ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ 5+

Drug/Substance Abuse... ☐ No ☐ Yes If Yes, Discuss With Doctor

Exercise..... ☐ Never ☐ <1 ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ 5+

Kinds Of Exercise You Do:

- ☐ Walking ☐ Jogging ☐ Cycling ☐ Swimming
☐ Golf ☐ Tennis ☐ Strength Training
☐ Other: _____

G. MEDICAL HISTORY

1. HEALTH CARE

a. Have You Ever Been To A Chiropractor? ☐ Yes ☐ No

b. Do You Have A Family Physician ☐ Yes ☐ No

Date Of Last Physical Exam: _____

Physician's Name: _____

Address: _____

Phone: () _____

c. Have You Been Hospitalized In The Past? . . . ☐ Yes ☐ No

Date & Reason For Hospitalization: _____

d. Have You Ever Had Surgery? ☐ Yes ☐ No

Date, Reason, Results Of Surgery: _____

e. Have You Ever Had A Serious Accident/Injury? ☐ Yes ☐ No

List Date & Describe Injury: _____

☐ Auto: _____

☐ Work-Related: _____

☐ Personal: _____

☐ Sports Injury: _____

☐ Other: _____

f. Are You Currently Taking Any Vitamins, Minerals, Or Herbs? (List Supplements) ☐ Yes ☐ No

g. Are You Currently Taking Any Medications? ☐ Yes ☐ No

For What Condition(s) Are You Taking Medication?

☐ Anti-inflammatory (Aspirin, Ibuprofen, Motrin, etc.): _____

☐ Pain/Analgesics: _____

☐ Anti-Depressants: _____

☐ Muscle Relaxants: _____

☐ Blood Pressure Pills: _____

☐ Antibiotics: _____

☐ Birth Control Pills: _____

☐ Corticosteroid: _____

☐ Other: _____

In The Past Have You Use Any Of The Following?

☐ Birth Control Pills ☐ Corticosteroid

h. Are You Allergic To Any Medications? ☐ Yes ☐ No

List Medications: _____

HEALTH STATUS QUESTIONNAIRE (CONTINUED)

G. How much bodily pain have you had during the past four weeks?

[MARK ONLY ONE ANSWER]

- ☐ None
 ☐ Mild
 ☐ Severe
☐ Very mild
 ☐ Moderate
 ☐ Very severe

H. During the past four weeks how much did pain interfere with your normal work (including both work outside the home and housework?)

[MARK ONLY ONE ANSWER]

- ☐ Not at all
 ☐ Moderately
 ☐ Extremely
☐ A little bit
 ☐ Quite a bit

I. These questions are about how you feel and how things have been with you during the past four weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past four weeks

[MARK ONLY ONE ANSWER ON EACH LINE]

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
1. Did you feel full of pep?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
2. Have you been a very nervous person?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
3. Have you felt so down in the dumps that nothing could cheer you up?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
4. Have you felt calm and peaceful?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
5. Did you have a lot of energy?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
6. Have you felt downhearted and blue?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
7. Did you feel worn out?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
8. Have you been a happy person?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
9. Did you feel tired?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6

J. During the past four weeks how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

[MARK ONLY ONE ANSWER]

- ☐ All of the time
 ☐ Some of the time
 ☐ None of the time
☐ Most of the time
 ☐ A little of the time

K. How TRUE or FALSE is each of the following statements for you?

[MARK ONLY ONE ANSWER ON EACH LINE]

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
1. I seem to get sick a little easier than other people.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
2. I am as healthy as anybody I know.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
3. I expect my health to get worse.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
4. My health is excellent.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5

L. Please answer YES or NO

[MARK ONLY ONE ANSWER ON EACH LINE]

	Yes	No
1. In the past year, have you had two weeks or more during which you felt sad, blue, or depressed; or when you lost all interest or pleasure in things that you usually cared about or enjoyed?	<input type="radio"/> 1	<input type="radio"/> 2
2. Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?	<input type="radio"/> 1	<input type="radio"/> 2
3. Have you felt depressed or sad much of the time in the past year?	<input type="radio"/> 1	<input type="radio"/> 2

Additional Comments:


SIGNATURE:

DATE:

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities.

Please answer **each section** by darkening the **one bubble** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **please, just pencil in the one choice which closely describes your problem now.**

Please use a **No. 2 pencil** to fill in your answer.
Fill in bubbles **completely** as indicated here: 
Erase changes cleanly. **Do not fold** this form.

Patient Name:

MO DAY YEAR

DR#

PATIENT NUMBER

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

1. PAIN INTENSITY

- ☐ A I have no pain at the moment.
- ☐ B The pain is very mild at the moment.
- ☐ C The pain is moderate at the moment.
- ☐ D The pain is fairly severe at the moment.
- ☐ E The pain is very severe at the moment.
- ☐ F The pain is the worst imaginable at the moment.

2. PERSONAL CARE

- ☐ A I can look after myself normally without causing extra pain.
- ☐ B I can look after myself normally, but it causes extra pain.
- ☐ C It is painful to look after myself and I am slow and careful.
- ☐ D I need some help, but manage most of my personal care.
- ☐ E I need help every day in most aspects of self care.
- ☐ F I do not get dressed, I wash with difficulty and stay in bed.

3. LIFTING

- ☐ A I can lift heavy weights, without extra pain.
- ☐ B I can lift heavy weights, but it gives extra pain.
- ☐ C Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned, for example, on a table.
- ☐ D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ E I can lift very light weights.
- ☐ F I cannot lift or carry anything at all.

4. READING

- ☐ A I can read as much as I want to with no pain in my neck.
- ☐ B I can read as much as I want to with slight pain in my neck.
- ☐ C I can read as much as I want with moderate pain in my neck.
- ☐ D I cannot read as much as I want because of moderate pain in my neck.
- ☐ E I cannot read as much as I want because of severe pain in my neck.
- ☐ F I cannot read at all.

5. HEADACHES

- ☐ A I have no headaches at all.
- ☐ B I have slight headaches which come infrequently.
- ☐ C I have moderate headaches which come infrequently.
- ☐ D I have moderate headaches which come frequently.
- ☐ E I have severe headaches which come frequently.
- ☐ F I have headaches almost all the time.

6. CONCENTRATION

- ☐ A I can concentrate fully when I want to with no difficulty.
- ☐ B I can concentrate fully when I want to with slight difficulty.
- ☐ C I have a fair degree of difficulty in concentrating when I want to.
- ☐ D I have a lot of difficulty in concentrating when I want to.
- ☐ E I have a great deal of difficulty in concentrating when I want to.
- ☐ F I cannot concentrate at all.

7. WORK

- ☐ A I can do as much work as I want to.
- ☐ B I can only do my usual work, but no more.
- ☐ C I can do most of my usual work, but no more.
- ☐ D I cannot do my usual work.
- ☐ E I can hardly do any work at all.
- ☐ F I cannot do any work at all.

8. DRIVING

- ☐ A I can drive my car without any neck pain.
- ☐ B I can drive my car as long as I want with slight pain in my neck.
- ☐ C I can drive my car as long as I want with moderate pain in my neck.
- ☐ D I cannot drive my car as long as I want because of moderate pain in my neck.
- ☐ E I can hardly drive at all because of severe pain in my neck.
- ☐ F I cannot drive my car at all.

9. SLEEPING

- ☐ A I have no trouble sleeping.
- ☐ B My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ C My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ D My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ E My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ F My sleep is completely disturbed (5-7 hours sleepless).

10. RECREATION

- ☐ A I am able to engage in all of my recreational activities, with no neck pain at all.
- ☐ B I am able to engage in all of my recreational activities, with some pain in my neck.
- ☐ C I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- ☐ D I am able to engage in a few of my usual recreational activities because of pain in my neck.
- ☐ E I can hardly do any recreational activities because of pain in my neck.
- ☐ F I cannot do any recreational activities at all.

After Vernon & Mior, 1991

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SIGNATURE:

DATE:

NP1b Pg-1

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REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities.

Please answer each section by darkening the **one bubble** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **please, just pencil in the one choice which most closely describes your problem right now.**

Please use a **No. 2 pencil** to fill in your answers.

Fill in bubbles **completely** as indicated here:

Erase changes cleanly. **Do not fold** this form.

Patient Name:

MO DAY YEAR

DR#

PATIENT NUMBER

[illegible]

From: N.Hudson, K. Tome-Nicholson, A Breen; 1989
Revised 09/11/92

1. PAIN INTENSITY

- ☐ A The pain comes and goes and is very mild.
- ☐ B The pain is mild and does not vary much.
- ☐ C The pain comes and goes and is moderate.
- ☐ D The pain is moderate and does not vary much.
- ☐ E The pain comes and goes and is severe.
- ☐ F The pain is severe and does not vary much.

2. PERSONAL CARE

- (A) I would not have to change my way of washing or dressing in order to avoid pain.
- (B) I do not normally change my way of washing or dressing even though it causes some pain.
- (C) Washing and dressing increases the pain, but I manage not to change my way of doing it.
- (D) Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- (E) Because of the pain, I am unable to do some washing and dressing without help.
- (F) Because of the pain, I am unable to do any washing or dressing without help.

3. *LIFTING*

- (A) I can lift heavy weights without extra pain.
- (B) I can lift heavy weights, but it causes extra pain.
- (C) Pain prevents me from lifting heavy weights off the floor.
- (D) Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e. g., on a table.
- (E) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- (F) I can only lift very light weights, at the most.

4. WALKING

- ☐ A Pain does not prevent me from walking any distance.
- ☐ B Pain prevents me from walking more than one mile.
- ☐ C Pain prevents me from walking more than 1/2 mile.
- ☐ D Pain prevents me from walking more than 1/4 mile.
- ☐ E I can only walk while using a cane or on crutches.
- ☐ F I am in bed most of the time and have to crawl to the toilet.

5. SITTING

- ☐ A I can sit in any chair as long as I like without pain.
☐ B I can only sit in my favorite chair as long as I like.
☐ C Pain prevents me from sitting more than one hour.
☐ D Pain prevents me from sitting more than 1/2 hour.
☐ E Pain prevents me from sitting more than ten minutes.
☐ F Pain prevents me from sitting at all.

6. *STANDING*

- ☐ A I can stand as long as I want without pain.
- ☐ B I have some pain while standing, but it does not increase with time.
- ☐ C I cannot stand for longer than one hour without increasing pain.
- ☐ D I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ E I cannot stand for longer than ten minutes without increasing pain.
- ☐ F I avoid standing, because it increases the pain straight away.

7. SLEEPING

- (A) I get no pain in bed.
- (B) I get pain in bed, but it does not prevent me from sleeping well.
- (C) Because of pain, my normal night's sleep is reduced by less than one-quarter.
- (D) Because of pain, my normal night's sleep is reduced by less than one-half.
- (E) Because of pain, my normal night's sleep is reduced by less than three-quarters.
- (F) Pain prevents me from sleeping at all.

8. SOCIAL LIFE

- ☐ A My social life is normal and gives me no pain.
- ☐ B My social life is normal, but increases the degree of my pain.
- ☐ C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- ☐ D Pain has restricted my social life and I do not go out very often.
- ☐ E Pain has restricted my social life to my home.
- ☐ F I have hardly any social life because of the pain.

9. TRAVELING

- (A) I get no pain while traveling.
- (B) I get some pain while traveling, but none of my usual forms of travel make it any worse.
- (C) I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- (D) I get extra pain while traveling which compels me to seek alternative forms of travel.
- (E) Pain restricts all forms of travel.
- (F) Pain prevents all forms of travel except that done lying down.

10. CHANGING DEGREE OF PAIN

- Ⓐ My pain is rapidly getting better.
- Ⓑ My pain fluctuates, but overall is definitely getting better.
- Ⓒ My pain seems to be getting better, but improvement is slow at present.
- Ⓓ My pain is neither getting better nor worse.
- Ⓔ My pain is gradually worsening.
- Ⓕ My pain is rapidly worsening.

ACCIDENT / INJURY 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.

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.

Patient Name:

MO DAY YEAR

DR#

PATIENT NUMBER

1	7	1	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	6
20	8	70	7	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	8
40	9		9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9

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?

<input type="radio"/> Head	<input type="radio"/> Shoulders	<input type="radio"/> Buttocks
<input type="radio"/> Neck	<input type="radio"/> Arms	<input type="radio"/> Hips
<input type="radio"/> Upper / Mid Back	<input type="radio"/> Elbows	<input type="radio"/> Thighs
<input type="radio"/> Lower Back	<input type="radio"/> Forearms	<input type="radio"/> Knees
<input type="radio"/> Pelvis	<input type="radio"/> Wrists	<input type="radio"/> Legs
<input type="radio"/> Chest / Rib Cage	<input type="radio"/> Hands	<input type="radio"/> Ankles
<input type="radio"/> Abdomen		<input type="radio"/> Feet
<input type="radio"/> Other _____		

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

<input type="radio"/> Head	<input type="radio"/> Shoulders	<input type="radio"/> Buttocks
<input type="radio"/> Neck	<input type="radio"/> Arms	<input type="radio"/> Hips
<input type="radio"/> Upper / Mid Back	<input type="radio"/> Elbows	<input type="radio"/> Thighs
<input type="radio"/> Lower Back	<input type="radio"/> Forearms	<input type="radio"/> Knees
<input type="radio"/> Pelvis	<input type="radio"/> Wrists	<input type="radio"/> Legs
<input type="radio"/> Chest / Rib Cage	<input type="radio"/> Hands	<input type="radio"/> Ankles
<input type="radio"/> Abdomen		<input type="radio"/> Feet
<input type="radio"/> 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? b. By whom were you driven?

<input type="radio"/> Hospital	<input type="radio"/> Home	<input type="radio"/> Myself	<input type="radio"/> Ambulance
<input type="radio"/> School	<input type="radio"/> Work	<input type="radio"/> Friend	<input type="radio"/> Family Member
<input type="radio"/> Other _____		<input type="radio"/> 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)?

<input type="radio"/> Head	<input type="radio"/> Shoulders	<input type="radio"/> Buttocks
<input type="radio"/> Neck	<input type="radio"/> Arms	<input type="radio"/> Hips
<input type="radio"/> Upper / Mid Back	<input type="radio"/> Elbows	<input type="radio"/> Thighs
<input type="radio"/> Lower Back	<input type="radio"/> Forearms	<input type="radio"/> Knees
<input type="radio"/> Pelvis	<input type="radio"/> Wrists	<input type="radio"/> Legs
<input type="radio"/> Chest / Rib Cage	<input type="radio"/> Hands	<input type="radio"/> Ankles
<input type="radio"/> Abdomen		<input type="radio"/> Feet
<input type="radio"/> Other _____		

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 ☐ Sutures ☐ Splint ☐ Collar
☐ Injection ☐ Ice Packs ☐ Cast ☐ Support
☐ Topical Antiseptics ☐ Hot Packs ☐ Brace ☐ Surgery
☐ Bandages ☐ Other

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

