# CONFIDENTIAL PATIENT INFORMATION PLEASE PRINT

DATE	- 1	' 1	1

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 $\square$ MARRIED $\square$ 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 ☐ V	ISA ☐ MASTERCARD ☐ AMEX ☐ DISCOVER ☐ OTHER ☐
INSURANCE INFORMATION:	
RELATIONSHIP TO INSURED? SELF ☐ SPOUSE ☐ O	THER  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
	ZIP CODE PHONE#()
	GROUP NUMBER
***************************************	***************************************
	ADDRESS
	ZIP CODE PHONE#()
POLICY NUMBER	GROUP NUMBER
the party who accepts assignment.  B. I authorize payment of any medical benefit from third-parties for b payment to this office of any sum I now or hereafter owe this office by company contractually obligated to make payment to me or you base C. I understand and agree that health and accident policies are an a this office will prepare any necessary reports and forms to assist me paid directly to this office will be credited to my account upon receipt directly to me and that I am personally responsible for payment. I als products or professional services rendered will be immediately due a	rrangement between an insurance carrier and myself. Furthermore, I understand that in making collection from the insurance company and that any amount authorized to be. However, I clearly understand and agree that all services rendered to me are charged so understand that if I suspend or terminate my care and treatment, any fees for nd payable.
Patient's Signature:	Date:
Guardian Signature:	Date:

## **VERIFICATION OF INSURANCE BENEFITS**

<b>IF GROUP INSURANCE:</b> 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	OUT OF NETWORK BENEFITS
Amount of Deductible:\$/Individual \$/Family	Amount of Deductible:\$/Individual \$/Family
Deductible met? YES ☐ NO ☐ \$ Remaining	Deductible met? YES ☐ NO ☐ \$ Remaining
Deductible Calendar ☐ or Fiscal ☐ Renewal Date//	Deductible <b>Calendar</b> □ or <b>Fiscal</b> □ Renewal Date <u>/</u>
Max. Yearly Benefit ? \$ Co-pay \$ % Coverage	Max. Yearly Benefit ? \$ Co-pay \$ % Coverage
Max. Yearly Visit Limit?	Max. Yearly Visit Limit?
Orthotics Coverage (CPT Code: L3030)? YES 🗆 NO 🗆 \$	Orthotics Coverage (CPT Code: L3030)? YES 🗆 NO 🗆 \$
Exclusions/Limitations:	Exclusions/Limitations:
Notes:	
Spoke to Whom?	Mail Claims to:
Direct Telephone:	Address:
IF AUTO ACCIDENT	City State Zip
Who was found at fault / ticketed $$ Patient $\Box$ Other Driver $\Box$	
Insured Auto Insurance Carrier	Address
City State ZIP Co	ode Phone#()
POLICY NUMBER	CLAIM NUMBER
Adjuster for the Claim?	Coverage Verified?
Deductible Amount? \$ Spoke to Whom?	
Does your auto insurance coverage have <b>Medical Payments</b> Coverage	ge? YES 🗆 NO 🗆
If yes, Auto Insurance Carrier	Address
City State ZIP Co	ode Phone#()
POLICY NUMBER	CLAIM NUMBER
Adjuster for the Claim?	Coverage Verified?
Deductible Amount? \$ Spoke to Whom?	
ATTORNEY'S NAME	PHONE#()
Employer's Name	Employer's #()
Employer's Address:	Is patient Currently Employed at Same?
Has the injury been reported? YES $\square$ NO $\square$ Has care been	authorized? ? YES 🗆 NO 🗆 By whom?
Employer's Insurance Carrier	Address
CityState ZIP Code	Phone#()
POLICY NUMBER	GROUP NUMBER

-HEALTH							22	,	tient Name:					
Use a <b>No. 2 p</b> bubble please								MO	DAY YEAR	DR#	PA	TIENT	NUMB	ER
indicated here								<u> </u>	① ①		000			
					<del></del>	21-19 1 170 m		(D) (B)	② <b>①</b> ①	000				
. PATIENT I	INFO	PRMAT	ION					<b>3 9</b>	3 20 2	222	(D) (D) (Z	2	222	222
larital Status:	Se	x:		Pa	tient Liv	es With:		(4) (10) (5) (10)	4 30 3 5 40 4	3 3 3 4 4 4				
○ Single		$\bigcirc$ M	$\bigcirc$ F		Alone			< <u>6</u> > (12)	<b>6 50 5</b>	<b>5</b> 55	<b>3 3</b>	<b>5 5</b>	<b>3 3</b>	<b>5</b>
<ul><li>Married</li><li>Separated</li></ul>	C	nildren:			<ul><li>Spous</li><li>Childr</li></ul>	se ⊜rkoo en ⊝Ass	omate(s) sisted Living		10 7 60 6 20 8 70 7	6 6 6 D D D				1 1 1
Divorced	O,	<b>10 1 2</b>	3005		Other				30 9 80 3	333	333	3 3	<b>® ® 0</b>	<b>3</b> 3 3
■ ○ Widowed									. 90 (9)	999	999	(D)	999	999
<b>B. PATIEN</b>	T'S	COMF	LAIN	TS 1.	. Mark Yo	our Presen	t Complain	ts Belo	OW OPhy	sical Exan	nination	with i	no com	plaints
Neck / Back				ر و دسمر	1 1 1				Occasional trees	Park / At / /s		S/8//		
7			Callet all	Junion dir.	Hress ressing	Arress Mild Moderate	are Burning France	hooting ho	Occasional ite	Corestant Improv	ing ind reso	14		
		Left	. * Y X / 1D (1D		② ② <b>◎</b>	W W 3	®©©©©	2			OD RD	When	Did You /Back	ır
	Veck	:	1 1 1		(S) (S) (W)	(M) (M) (S)	$\mathfrak{B}\mathfrak{D}\mathfrak{S}\mathfrak{S}$	·	<b>O D D C</b>		(D) (B)	Com	plaints E	Begin?
	Jpr	Left	<del></del>		(S) (S) (W)	<b>M M S</b>	(B) (D) (S) (S	(A) (D)	0000		(U) (R)	○ Da	te:	
	Back	Right	<b>® ® ®</b>	DOO	(S) (S) (W)		<b>B D S</b>	(D) (D)	@ (D (B) (C)		(D) (B)		1 1	
	Mid	Left	(P) (T	D (ID) (ID)	(S) (S) (W)	M M S	<b>BOS</b>	(A) (D)	<b>©</b> (D) (D) (E)	0 0	(U) (B)			
	3ack	Right	(S) (D) (I	D CO CO	$\odot$	M M S	$\mathbb{B}\mathbb{D}\mathbb{S}\mathbb{S}$		@ D D @	D 000	(I) (R)			
	ow	Left	J		(S) (S) (W)	(M) (M) (S)	<b>B D S S</b>	T	<b>O</b> OOO					
	3ack				(S) (S) (W)		B D 3	-!		i				
\ \ \ F	Ribs	Left		,	(S) (S) (W)	(M) (M) (S)	B D S S	i						
		Kignt		3i	(S) (S) (W)		<b>BDS</b>	.1			(I) (R)			
Upper Extremi	ition		AS	Wilding Co.	d -55 055 00	And Mild Modelate	ere purting bar	10g A	Occasional tre	oft art is	® R R R R R R R R R R R R R R R R R R R	led/		
opper extrem	nies		24 Proche	Willip, Hollis	Hressnessing	Wild Hodelate	ere Burning	hoothing	obbins Occasionalitie	onstant Ingrav	ree, right	34/ban	nia V	
	SI	noulder	@ O		\$ \$ \$ \$ \$ \$	(M) (M) (S)	B D S S	<b>A C</b>			(D) (B)	Uppe	Did You r Extren	mity
	L A	m	(S) (P) (A	DOS	S S W	(E) (M) (S)	® ® ® ®	(D) (D)	@ D D @		(D) (B)	1	plaints E	
Shoulder	EE	bow	(S) (P) (A	DOS	SSW)	M M 3	B D S S		$\odot \odot \odot \odot \odot$		(I) (B)		me Date eck/Bac	As k
1		orearm	<b>S</b> OO		(S) (S) (W)	M $M$ $S$	(B) (D) (S) (S		$\odot$ $\bigcirc$ $\bigcirc$	D (80)	OD B			
Arm	TW				(S) (S) (W)	$\mathbf{M}$	<b>B D S S</b>	<b>A D</b>	$\odot$ $\odot$ $\odot$		<b>D B</b>	O Dif	ferent D	ate:
		nd/Fgrs	(S) (P) (A	DOD	S S W		B O S		$\odot$ $\odot$ $\odot$		(D) (R)		1 /	
Forearm												L		
Wrist S		noulder m		<del></del>	<b>3 3 8</b>		® ® ® ®			-1 1				
M					S S W	(M) (M) (S)	® ® ® ®	<u> </u>						
#####################################	O E				\$ \$ W		B D S S		@ D D @	7				
THE GIO	£.7				(S) (S) (W)	(M) (M) (S)	B D S S		@ D D @	_;				
Lower		nd/Fgrs	(S) (P) (N	D D S	\$ \$ W	M $M$ $S$	BOSS		@ D D @					
Extremities							<u> </u>					When	Did You	r
Buttock	Hi		(P) (N		(I) (I) (I)		(B) (D) (S) (S)	(I)	@ (D (D) (C)		U ®	Lowe	er Extren	mity
			(I) (I) (I)	D CD CD	<b>S S W</b>		$\mathbb{D}$ $\mathbb{O}$ $\mathbb{S}$		<b>©</b> D <b>E</b> C		U R			
Hip	-		i i		3 3 W	M M S	<b>BO</b>			i		O Sa N	me Date eck/Bac	k As
V 1	Ben	1ee			3 3 W		<b>BDS</b> S	<u></u>	@ ( ) ( ) ( )					
Thigh	3	~#	·		\$ \$ W		B D S S			7		O Dif	ferent D	ate:
	L		<del></del>		\$ \$ <b>W</b>		B D S S	4					1	
Knee		, от			3.3.4		® D S S							
	Hi	p	(P) (N		S S W	(M) (M) (S)	B D S S	(A) (D)	@ (D (D) (C)		(D) (R)			
Leg/ Calf		-			(S) (S) (W)	M M S	BDSS	1	@ D D @					
1			(S) (P) (N	D (T) (S)	\$ \$ <b>₩</b>	(M) (M) (S)	B D S S	1	<b>O D D C</b>					
Ankle			(I) (P) (N	000	3 3 W	M W S	$\mathbb{B}$ $\mathbb{D}$ $\mathbb{S}$		$\odot$ $\odot$ $\odot$		U B			
	* * *	m10-14		D (T) (S)	\$ \$ \$ ₩	CO CO CO	B D S S				(II) (B)			
		"US"	O P O								U) (K)			
Foot	TA		<del></del>		\$ \$ W	M M S	<b>BDS</b>	7 T	@ D D C					

B. PATIENT'S COMPLAI	NTS (CONTINUED	1	***********	100		WHEN THE STATE OF		
2. How Did Your Complaint(s			t Makas	Vour	Condition W	oreo?		
<ul><li>Unknown Suddenly</li></ul>			lothing		Coughing ⊃	orse : ⊝ Rea	china	Standin
3. What Happened To Cause (	_ ,	_	ineezing	<	⇒ Lifting		ng	<ul><li>Pulling</li></ul>
Your Complaint(s)?	or no riggiarate		lending Other	<	⇒ Walking	⊖ Silai	ining at Stool	O runnių
Cause Not Known	Auto Accident							
<ul><li>Work Accident/Injury</li><li>Personal Injury</li></ul>	<ul><li>Home Accident</li><li>Sport Injury</li></ul>	8. Hav	e Any Ol	f Your (	Complaint(s	) Existed In	The Past?	⊃Yes ⊝N
Other - Describe:		If Ye	s, Indica leck	te Belov	W	∕		
Other - Describe.		- $           -$	houlder	→ Arm	1 $\bigcirc$ Elbow	Forearm	○ Wrist	Hnd/fgr
	** * *** *** ***		Juttock oot	OHip Oth				Ankle
				_				
<ul><li>4. How Would You Rate Your 0</li><li>Where 0 Is No Pain And 10</li></ul>	Overall Pain Today	OUT	SIDE OF	This C	Office[1]?	atment For Y		
No 0 1 2 3 4 5 6 7 8	9 10 Worst Pain	$\circ$ Y	'es ⊝N	o If Ye	es, List Dates	s, Treatments	s, And Doctor	S.
5. When Are Your Symptoms								
Always The Same	Orvering Orvigin							
6. What Makes Your Condition	n Better?							
Nothing Stretching	⊖ Heat					Have You No	oticed A Cha	nge In?
Rest Exercise Sitting Standing		Blac	vei Functi dder Func	ion ∈ ction ∈	⊃Yes ⊃No	) 2_	<b>4</b> !!	
■ Other		Sex	ual Func	tion <	⊃Yes ⊃No	)		
C. HEADACHES								
If You Are Experiencing				is Sec	tion Othe	rwise Skip	To Section	m D.
1. Where is The Pain Associat				6		ns To Bring	On Your Hea	adaches?
Over Temporal Over F	rontal Over Frontal	O Over			<ul><li>Physica</li><li>Excessi</li></ul>	l Activity ve Stress	<ul><li>Caffeine</li><li>Certain F</li></ul>	onds:
Over Parietal			- N Po	ver orietal	<ul><li>Alcohol</li></ul>			ıl Period
· OHE VAN /	(A) / (2)	1/ 1			Other			
Base of Skull				126 OI	. <b>How Ofter</b> Times/Wee	Do They O		
Skull Ton Film		(4)	) ∫ Ski	ull ()	Times/Mon		) 4 5 6 7 ( ) 4 5 6 7 (	
			1		Other			
Jaw Joint	1 <del>(</del>	-f		OWNER		Do Your He		
(IMJ)		_	(IMJ)	) - ()	O Less Th	an 1 Hour Than 3 Hours	○ From 1-3 S ○ All Wakir	Hours
			,		<ul> <li>Several</li> </ul>	Hours To Da	iys	19 110010
Right   Behind Ey	re ' ' Behind Eye <b>  '</b> Over Sinuses	Left			Other			
2. On What Date Did Your Hea	idaches Begin[1]?		9 Do 1	Vour He	andachae W	ake You Fro	m Slaan[1]?	
Date: / / S	ame As Neck/Back Com	plaints	3. DO 1	0 05	Sometimes	<ul><li>Always</li></ul>		
						ng Occur W		idaches?
3. How Does The Intensity Of		<b>1</b> ],	$\bigcirc$ N	ausea∧		_ → Weakn	ess	
No 0 1 2 3 4 5 6 7 8	Possible		$\circ$ Tr	remor izziness	2	○ Vision I ○ Light/S	Problems Journal Sensitiv	vitv
4. What Describes Your Pain?			00			O Ligito O		
■ ○ Dull ○ Sharp ○ A ■ ○ Deep ○ Vice-Like ○ B	ching ⊝Stabbing urnina ⊝Throbbing/P	ulsatino	11.Wha	at Make	s Your Head	daches Bette	er?	
Other			: N	otning	→ Rest	Use the contract of the con	Jown 🔘 ice/	Cold Packs
5. When Do Your Headaches t	Jsually Start?					g ONSAID	S (Aspinn, 1)	/lenoi, etc.)
Constant/Anytime Awake	<ul><li>Wake Up With In Mo</li><li>During Evening</li></ul>	rning						
○ At Midday						77		
D. OTHER COMPLAINTS	S					Wei.		( <b>a</b> ) ( <b>a</b> )
Do you have any other co	omplaints not covere	d on ti	nis form	[1]?	⊃Yes ⊝No		<u>, , , , , , , , , , , , , , , , , , , </u>	
If Yes, Describe other com	plaints in detail and marl	k body a	ireas on l	Figures	·,			
								$_{i}$ $> Q_{i}$
•						7n° - '=	GAN GAN	M
							; ,	의 호
-								1.00

HEALTH QUESTIOI Patient's Name		What Are Your Current Habits? Packs Per Day
		Never <1 1-2 2-3 3-4 5+
		Glasses Per Day
REVIEW OF SYSTEMS		Caffeinated DrinksNever <1 1-2 2-3 3-4 5+
Are You Currently Suffering F Listed Below? If This Is A Re-I	rom Any Of The Symptoms	Glasses Per Day Alcohol Consumption Never <1 1-2 2-3 3-4 5+
isted Below? If This is A Re-I Symptoms Since Your Last Exa	am.	Alcohol Consumption Never <1 1-2 2-3 3-4 5+
	O No New Symptoms Since	Drug/Substance Abuse O Strug/Substance Abuse O If Yes, Discuss With Doctor
None Of The Symptoms     Listed Below	Your Last Exam	Days Per Week
		Exercise
⇒ General Fatigue	◯ Skin Rash	Kinds Of Exercise You Do:
⇒ Weakness	Redness Of Skin	○ Walking ○ Jogging ○ Cycling ○ Swimming
⇒ Fever (continuous)	Skin Itching	Golf Tennis Strength Training
Loss Of Sleep	○ Skin Dryness	Other:
○ Chills (continuous)	Eczema(red, inflamed skin)	
⇒ Weight Change (unplanned)		G. MEDICAL HISTORY
⇒ Night Sweats	Nail Changes (unplanned)	1.HEALTH CARE
Headaches	Bruise Easily	a. Have You Ever Been To A Chiropractor? Yes b. Do You Have A Family Physician
Dizziness	Cough (chronic)	
⇒ Fainting	Wheezing (chronic)	Date Of Last Physical Exam:
○ Convulsions	O Difficulty Breathing	Physician's Name:
Nervousness		Address: Phone:( )
⇒ Anxiety ⇒ Depression (prolonged)  □ D	<ul><li>○ Blue Extremities</li><li>○ Varicosities (visible veins)</li></ul>	c. Have You Been Hospitalized In The Past? Yes
⇒ Phobias (excessive fears)	Rapid Heart Beat	Date & Reason For Hospitalization:
	•	Date a Neason For Hospitalization.
→ Mood Swings (excessive)	⊖ Heart Palpitations	
Left Right		d. Have You Ever Had Surgery?
Hearing Trouble O O	Decreased Appetite	Date, Reason, Results Of Surgery:
Ringing in Ears	Increased Appetite	
Pain in Ears		
Ear Discharge 🔘 🔘	Hemorrhoids	e. Have You Ever Had A Serious Accident/Injury? Yes
Vision Trouble 🔘 🔾	Excess Gas	List Date & Describe Injury:
Pain in Eyes OO	Vomiting (excessive)	Auto:
Eye Discharge 🔘 🔾	Diarrhea (excessive)	○ Work-Related:
⊃ Nose/Sinus Pain	Constipation (excessive)	OPersonal:
⇒ Excessive Drainage	○ Heartburn/Indigestion	Sports Injury:
Nose Bleeds (chronic)	○ Painful Urination	Other:
Nasal Infections (chronic)	Inability To Hold Urine Executed Urington	f. Are You Currently Taking Any Vitamins, Minerals, Or Herbs? (List Supplements)
	<ul><li>Frequent Urination</li><li>Urinary Retention</li></ul>	Minerals, Or Herbs? (List Supplements)
⊝ iviouth Sores ⊝ Bleeding Gums	Bed-wetting	
⇒ Enlarged Glands	○ Irregular Menstruation	g. Are You Currently Taking Any Medications?
⇒ Absence Of Taste	Painful Menstruation	For What Condition(s) Are You Taking Medication?
⇒ Abnormal Taste Sensation	Abnormal Vaginal Bleeding	
→ Tonsillitis/Infected Tonsils		
Difficulty With Swallowing	○ Impotence	⊝ Pain/Analgesics:
→ Heat/Cold Intolerance	○ Lumps In Breast(s)	
⇒ Sugar In Urine	○ Redness/Itching of Breast	
─ Goiter (enlargedThyroid gland)		○ Blood Pressure Pills:
Tremor (shaking)	Discharge from Breast(s)	O Antibiotics:
	○ Breast Pain	Birth Control Pills:
Other (Please Describe)		Corticosteroid:
		Other:
		In The Past Have You Use Any Of The Following?
		<ul> <li>○ Birth Control Pills</li> <li>○ Corticosteroid</li> <li>h. Are You Allergic To Any Medications? Yes</li> </ul>
		List Medications:

To Your Knowledge, Are You Pregnants to Programatics Normal?  Are You Soing An OB-GYN Regularly?  Number of Births:	G. MEDICAL HISTORY -		H. OCCUPATIONAL INFORMATION - ACTIVITIES OF DAILY LIVING
## Pregrant in Past, Were Pregrancies Normal?	AND ASSESSMENT OF THE PROPERTY	# ### A ###	
Are You Seeing An OB-GYN Regularly?  Date Of Last Exam: Physician is Name Address:  Phone: Ph			I. Are roungin or contranded: Origin Ocon
Number Of Births: □□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□			2. Job Type
Physician Name   Address:   Phone:	4.5		
Physician's Name Address:  Phone:  2. FAMILY HISTORY  2. Described College of the provided of the part of			
2. FAMILY HISTORY  2. FAMILY HISTORY  2. FAMILY HISTORY  Fighter			
2. FAMILY HISTORY  3. During Your Work Week, You Work How Many: Hours Per Day	Address:		
## Hours Per Day  ## De-drow the drow the dr		Phone:( <u>    )</u>	
Days Per Week	<b>-</b>		1 V 200. 100.
Months © Describe Others  3. Conditions Or Illinesses Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  No Emphysican are Discontinuous Phone and	■ 2. FAMILY HISTORY	<del>7777777777777777</del>	
Months © Describe Others  3. Conditions Or Illinesses Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  No Emphysican are Discontinuous Phone and	<b>-</b> / / / <b>/3</b> / / <b>3</b> /	/	
Months © Describe Others  3. Conditions Or Illinesses Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  No Emphysican are Discontinuous Phone and	<b>-</b> / /3/2/ /3/2/		Other
Months © Describe Others  3. Conditions Or Illinesses Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  No Emphysican are Discontinuous Phone and	<b>-</b> /\$\\\$\\\$\\\$\\\$\\\$\\\$\\\$\\\$\\\$\\\$\\\$\\\$\\	<u> </u>	A How Long Have You Reen With Your Present Employe
Months © Describe Others  3. Conditions Or Illinesses Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  No Emphysican are Discontinuous Phone and		\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	
Months © Describe Others  3. Conditions Or Illinesses Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  Please Indicate If You Now Have or Have Had In The Past Arry Of The Following Illinesses:  No Current Or Previous Conditions/Illinesses  No Emphysican are Discontinuous Phone and		<u> </u>	16a15
Sisters   Cooperation   Coop			a # . y
Setters			MORRIS DOGGGGGGGGGGGGGGGGGGGGGGGGGGGGGGGGGGGG
Describe Others:  3. Conditions Or Illnesses Please Indicate If You Now Have or Have Had In The Past Any Of The Following Illnesses:  No Current Or Previous Conditions/Illnesses  Sinus Trouble Describes Des			5 Do Your Present Complaints Affect The Number
Bescribe Others:  3. Conditions Or Illnesses Please indicate If You Now Have or Have Had In The Past Any Of The Following Illnesses:  ○ No Current Or Previous Conditions/Illnesses  ○ No Current Or Previous Conditions/Illnesses  ○ No Sirus Trouble ○ ○ Sirus Trouble ○ ○ Sirus Trouble ○ ○ Sirus Trouble ○ ○ Distinary Retention ○ ○ Desprise Continuous Phone ○ Desprise Province Continuous Province Continuous Phone ○ Desprise Province Continuous Province Continuous Province Continuous Province Continuous Province Contin			
3. Conditions Or Illnesses Please Indicate If You Now Have or Have Had In The Past Any Of The Following Illnesses:  No Current Or Previous Conditions/Illnesses    No Current Or Previous Conditions/Illnesses			1
3. Conditions Or lilnesses Please indicate If You Now Have Any Of The Following lilnesses:  No Current Or Previous Conditions/lilnesses  © Sinus Trouble © Sinus Trouble © Shaftma © Semphysema © Semphysema © Semphysema © Semphysema © Sociesis © Diabetes © Sinus Trouble © Semphysema © Sociesis © So	Describe Others.		6. What Is Your Primary Work Position and Location?
Please Indicate If You Now Have or Have Had In The Past Any Of The Following Illnesses:  No Current Or Previous Conditions/Illnesses  So Sinus Trouble  Description Descriptio			
Any Of The Following Illnesses:  No Current Or Previous Conditions/Illnesses  No Current Or Previous Conditions/Illnesses  Search of Conditions/Illnesses  Description of Conditions  Description of Conditions/Illnesses  Description of Conditions/Illnesses  Description of Conditions  Desc	3. Conditions Or Illnesse	S	○ Seated ○ Standing ○ Desk ○ Counter ○ Workbench
No Current Or Previous Conditions/Illnesses	Please Indicate If You Now	Have or Have Had In The Past	Other Other
## Disbetes ## Discressifainting ## Discressifainti	Any Of The Following Illne:	sses:	
By Des Your Work Include Any Of The Following Use?  Description De	■ ○ No Current Or Previous	Conditions/Illnesses	
By Des Your Work Include Any Of The Following Use?  Description De	<b>-</b>		
By Des Your Work Include Any Of The Following Use?  Description De	■ Ži oß	ž o <sup>ž</sup>	
By Des Your Work Include Any Of The Following Use?  Description De	- 2 5	8 4	Carrying Other
## Prolonged Computer	m (h) (b) Silius Houple	P Kidney Frouble	O Dane Variable de la chada Anna Of The Fellowine Hand
## Prostate Trouble ## Description	and the second s	•	
## Description   ## Des			Continuous Phone
Describes to the feeting of Infection to the Dislocated Joints (Choose Only Ore) Constantly    How Many Pounds? © Dos Dislocated Joints (Choose Only Ore) Octavity At Work?   None			9 Does Your Joh Involve Liffing?
## Description			
## Dislocated Joints ## Cancer/Tumor ## Dislocated Joints ## Dislocated			
## Cancer/Tumor ## Spinal Disc Disease ## Pounds  ## Diabetes ## D			
Diabetes Diabetes Distribution Distribution Distribution Difficulty Distribution Distri		· ·	(Choose Only One)
## Dizziness/Fainting	i yang a g	•	
Dizziness/Fainting Dizziness/Fai	N 47 4 1999 F 1 4		10.What Best Describes Your Stress Level At Work?
<ul> <li>Description of Trouble</li> <li>Description of Trouble of Trouble of Trouble</li> <li>Description of Trouble of</li></ul>			○ None ○ Minimal ○ Minimal To Moderate
## Description of Trouble			
B	1 1 1	Mental/Emotional Difficulty	
## Abnormal Weight Gain ## Abnormal Weight Loss ## Abnormal Weight Cain ## Abnormal Weight Cain ## Abnormal Weight Loss ## Abn		® Sex. Trans. Diseases	
## Pacemaker	■ ® Low Blood Pressure		
B			
B Acrtic Aneurysm B Numbness Groin/Buttocks C Anemia C Other: C An	!	-	
##	A GRANDANIAN AND A CONTRACT OF	-	
B Polio B Polio B P Multiple Sclerosis B P Ulcer B P Liver Trouble  PATIENT'S SIGNATURE  PATIENT'S SIGNATURE			
B Polio B Multiple Sclerosis D Other: D D Ulcer D D Liver Trouble		① Other:	Yes No It Yes, Explain:
Multiple Sclerosis     Multiple Sclerosi			
PATIENT'S SIGNATURE DATE:  Description of the control of the contr			
●		① Other:	DATIENT'S SIGNATURE DATE.
			FATIENT S SIGNATURE DATE.
	D Liver Irouble		
			PLEASE MAKE NO MARKS IN THIS AREA

■HQ3a Pg-4 Printed in The USA

EW-239487-2:22

_HEALIH STATUS QUESTIONNAIR	<b>-</b>	Patient Name:	DR#	PATIENT	NUMBER
Please Read: This survey asks for your views about you The information will help your health care provider track ho and how well you are able to do your usual activities.	ow you feel	(C)	0000	0000°	00000 00000 00000
Answer every question by filling in the appropriate bubble. unsure about how to answer a question, please give the beyon can and make a comment at the end of the questionnal	If you are est answer ire.	300 000 300 000 300 000	00000 0000	0000 0000	00000 0000 0000
Please use a <b>No. 2 pencil</b> to fill in your answers Fill in bubbles <b>completely</b> as indicated here: <b>Erase</b> changes cleanly. Do <b>not fold</b> this form.		\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	00000 00000 00000	0000 0000 0000	\$\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
A. In general, would you say your health is:  [MARK ONLY ONE ANSWER]  ① Excellent ② Very good ③ Good ② Fair ③ Poor	① ② ③ ④	npared to one ye th in general now Much better now Somewhat better About the same Somewhat worse Much worse now	than one yea now than one now than on	r ago e year ago e year ago	
C. The following items are about activities you might do  Does your health now limit you in these activities? If [MARK ONLY ONE ANSWER ON EACH LINE]  1. Vigorous activities, such as running, lifting heavy obje 2. Moderate activities, such as moving a table, pushing a 3. Lifting or carrying groceries 4. Climbing several flights of stairs 5. Climbing one flight of stairs 6. Bending, kneeling, or stooping 7. Walking more than a mile 8. Walking several blocks 9. Walking one block 10. Bathing or dressing yourself	so, how much ects, participatin a vacuum clear	g in strenuous sp	orts caying golf caying golf caying golf caying golf caying golf caying caying caying a caying cayin	D Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q	
During the past four weeks, have you had any of the faily activities as a result of your physical health?  [MARK EITHER YES OR NO ON EACH LINE]  1. Cut down the amount of time you spent on work or other accomplished less than you would like  3. Were limited in the kind of work or other activities  4. Had difficulty performing the work or other activities (for	her activities	Ye	es No D © D O	regular	
E. During the past four weeks, have you had any of the fo daily activities as a result of any emotional problems (s  [MARK EITHER YES OR NO ON EACH LINE]  1. Cut down the amount of time you spent on work or off 2. Accomplished less than you would like  3. Didn't do work or other activities as carefully as usual	uch as feeling of Yellow the Activities	depressed or an les No	ork or other re kious)?	egular	
F. During the past four weeks, to what extent has your production your normal social activities with family, friends, neight [MARK ONLY ONE ANSWER]  ① Not at all ② Quite a bit ② Slightly ③ Extremely ③ Moderately	ohysical health bors, or groups	or emotional pi	oblems inte	rfered with	}

© 2004 Document Plus Technologies, Inc., Atlanta, GA

PLEASE MAKE NO MARKS IN THIS AREA

HS1a Pg-1

Printed In The USA

226500

	How much bodily pain have you had during the past four weeks? [MARK ONLY ONE ANSWER]						
	① None ② Mild ③ Severe						
	© Very mild						
Η.	During the past four weeks how much did pain interfere with your nor	mal wo	rk (inclu	ding			
	both work outside the home and housework?) [MARK ONLY ONE ANSWER]						
	© Not at all						
	② A little bit ② Quite a bit						
۷.	These questions are about how you feel and how things have been wi each question, please give the one answer that comes closest to the w	th you c	luring th have be	ne <u>past fo</u> en feelin	our wee	ks. For	
	How much of the time during the past four weeks	\$ 3 \$ 3	10 25 ON 10	49000 S			1000 OF 1000 O
	[MARK ONLY ONE ANSWER ON EACH LINE]	\$ 4. \$ 9.	\$0°50°	42.2	બ <sup>ર્ડ</sup> કરે	4 2	20 5
	1. Did you feel full of pep?	<b>O</b>	(I) (I)	3	<b>4</b>	<u></u>	<b>6</b>
	2. Have you been a very nervous person?	Œ	<b>②</b>	<b>①</b>	<b>(4</b> )	<b>3</b>	<b>6</b>
	3. Have you felt so down in the dumps that nothing could cheer you up?	①	2	3	<b>4</b>	3	<u>(6)</u>
	Have you felt calm and peaceful?	0	2	3	4	(5)	6
	5. Did you have a lot of energy?	①	2	3	<b>4</b>	(5)	
	6. Have you felt downhearted and blue?	<b>①</b>	2	③	<b>④</b>	<b>5</b>	<b>⑤</b>
	7. Did you feel worn out? 8. Have you been a happy person?	<u> </u>	② ②	<u>(3)</u>	④	<b>5</b>	6
	9. Did you feel tired?	<u> </u>	. <u>D</u>	(3) (3)	4) 4)	<u> </u>	
<u>.</u> K.	⊕ All of the time ⊕ Some of the time ⊕ None of the time ⊕ Most of the time ⊕ A little of the time  How TRUE or FALSE is each of the following statements for you?				,		
<u>.</u> K.		Naj.		<u> </u>		Nay	· · · · · · · · · · · · · · · · · · ·
Κ.		Nonline of the second			1180	onniey Iso	
<b>K</b> .	© Most of the time  © A little of the time  How TRUE or FALSE is each of the following statements for you?  [MARK ONLY ONE ANSWER ON EACH LINE]		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		100 m		
K.	Most of the time  A little of the time  How TRUE or FALSE is each of the following statements for you?  [MARK ONLY ONE ANSWER ON EACH LINE]  1. I seem to get sick a little easier than other people.		\(\sigma_{\initin\s\cond\cond\ii\sigma_{\sigma_\sigma_\sigma_\ii\sigma_\ii\sigma_\ii\sigma_\ii\ii\sigma_\iii\sigma_\iii\ii\sigma_\iii\iii\ii\sigma_\iii\iii\ii\iii\iii\iii\iii\iii\iii\ii	3	4	3	
K.	Most of the time  A little of the time  How TRUE or FALSE is each of the following statements for you?  [MARK ONLY ONE ANSWER ON EACH LINE]  1. I seem to get sick a little easier than other people.  2. I am as healthy as anybody I know.			(I)	④ ④	<b>3</b>	
K.	Most of the time  A little of the time  How TRUE or FALSE is each of the following statements for you?  [MARK ONLY ONE ANSWER ON EACH LINE]  1. I seem to get sick a little easier than other people.		\(\sigma_{\initin\s\cond\cond\ii\sigma_{\sigma_\sigma_\sigma_\ii\sigma_\ii\sigma_\ii\sigma_\ii\ii\sigma_\iii\sigma_\iii\ii\sigma_\iii\iii\ii\sigma_\iii\iii\ii\iii\iii\iii\iii\iii\iii\ii	3	4	3	
	Most of the time  A little of the time  How TRUE or FALSE is each of the following statements for you?  [MARK ONLY ONE ANSWER ON EACH LINE]  1. I seem to get sick a little easier than other people.  2. I am as healthy as anybody I know.  3. I expect my health to get worse.			① ② ③	④ ④	(3) (3)	
	Most of the time  A little of the time  How TRUE or FALSE is each of the following statements for you?  [MARK ONLY ONE ANSWER ON EACH LINE]  1. I seem to get sick a little easier than other people.  2. I am as healthy as anybody I know.  3. I expect my health to get worse.  4. My health is excellent.			① ② ③	④ ④ ④ ④	(3) (3)	
	Most of the time  A little of the time  How TRUE or FALSE is each of the following statements for you?  [MARK ONLY ONE ANSWER ON EACH LINE]  1. I seem to get sick a little easier than other people.  2. I am as healthy as anybody I know.  3. I expect my health to get worse.  4. My health is excellent.  Please answer YES or NO		(D)	① ① ①	④ ④ ④ ④ ④ ④ ④ ④ ④ ④ ④ ④ ④ ④ ⑥ ⑥ ⑥ ⑥ ⑥ ⑥	(5) (5) (5)	
	Most of the time  A little of the time  How TRUE or FALSE is each of the following statements for you?  [MARK ONLY ONE ANSWER ON EACH LINE]  1. I seem to get sick a little easier than other people.  2. I am as healthy as anybody I know.  3. I expect my health to get worse.  4. My health is excellent.  Please answer YES or NO  [MARK ONLY ONE ANSWER ON EACH LINE]  In the past year have you had two weeks or more during which you feel.	θ θ θ elt sad, b outorer	(Live, or day)	③ ③ ④ epressed	④ ④ ④ ④ ④ ④ ④ ④ ④ ④ ⑥ ⑥ ⑥ ⑥ ⑥ ⑥ ⑥ ⑥ ⑥ ⑥	(5) (5) (5) (5)	
	Most of the time  A little of the time  How TRUE or FALSE is each of the following statements for you?  [MARK ONLY ONE ANSWER ON EACH LINE]  1. I seem to get sick a little easier than other people.  2. I am as healthy as anybody I know.  3. I expect my health to get worse.  4. My health is excellent.  Please answer YES or NO  [MARK ONLY ONE ANSWER ON EACH LINE]  1. In the past year, have you had two weeks or more during which you fe when you lost all interest or pleasure in things that you usually cared about the pool of the poo	θ θ θ elt sad, b outorer	(Live, or day)	③ ③ ④ epressed	④ ④ ④ ④ ④ ④ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	(3) (3) (3) (3) (4) (7) (7) (2)	
	Most of the time  A little of the time  How TRUE or FALSE is each of the following statements for you?  [MARK ONLY ONE ANSWER ON EACH LINE]  1. I seem to get sick a little easier than other people.  2. I am as healthy as anybody I know.  3. I expect my health to get worse.  4. My health is excellent.  Please answer YES or NO  [MARK ONLY ONE ANSWER ON EACH LINE]  1. In the past year, have you had two weeks or more during which you fewhen you lost all interest or pleasure in things that you usually cared about the pool of the pool	θ θ θ elt sad, b outorer	(Live, or day)	③ ③ ④ epressed	④ ④ ④ ④ ④ ④ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	(5) (5) (5) (6) (es No	
	Most of the time  A little of the time  How TRUE or FALSE is each of the following statements for you?  [MARK ONLY ONE ANSWER ON EACH LINE]  1. I seem to get sick a little easier than other people.  2. I am as healthy as anybody I know.  3. I expect my health to get worse.  4. My health is excellent.  Please answer YES or NO  [MARK ONLY ONE ANSWER ON EACH LINE]  1. In the past year, have you had two weeks or more during which you fe when you lost all interest or pleasure in things that you usually cared about the company of the time in the past year?  3. Have you felt depressed or sad much of the time in the past year?	θ θ θ elt sad, b outorer	(Live, or day)	③ ③ ④ epressed	④ ④ ④ ④ ④ ④ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	(5) (5) (5) (6) (es No	
	Most of the time  A little of the time  How TRUE or FALSE is each of the following statements for you?  [MARK ONLY ONE ANSWER ON EACH LINE]  1. I seem to get sick a little easier than other people.  2. I am as healthy as anybody I know.  3. I expect my health to get worse.  4. My health is excellent.  Please answer YES or NO  [MARK ONLY ONE ANSWER ON EACH LINE]  1. In the past year, have you had two weeks or more during which you fe when you lost all interest or pleasure in things that you usually cared about the company of the time in the past year?  3. Have you felt depressed or sad much of the time in the past year?	θ θ θ elt sad, b outorer	(Live, or day)	③ ③ ④ epressed	④ ④ ④ ④ ④ ④ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	(5) (5) (5) (6) (es No	

## \_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 c**ompletely** as indicated here: **Erase** changes cleanly. Do **not fold** this form.

	ent Name: DAY YEAR	DR#	PATIENT NUMBER
9	0	000	@@@@@@@@@@
<b>7</b> 3	$\mathbb{O} \oplus \mathbb{O}$	000	00000000000
<b>I</b>	320	000	$\Phi\Phi\Phi\Phi\Phi\Phi\Phi\Phi\Phi\Phi$
$\oplus$ $\textcircled{1}$	<b>333</b>	300	000000000000
<b>I</b>	<b>3 4 4</b>	444	@@@@@@@@@
® ®	@ <b>@</b> @	\$\text{\$\exitt{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\exitt{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\exitt{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\exitt{\$\text{\$\}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}	ଦେବ ଓ ଓ ଓ ଓ ଓ ଓ ଓ ଓ ଓ ଓ ଓ ଓ ଓ ଓ ଓ ଓ ଓ ଓ ଓ
Œ	0000	000	@@@@@@@@@@
Œ	0 <b>0</b> 0	900	DODDODDDDDD
9	O CO	333	®®®®®®®®®®
	(S)	999	@@@@@@@@@@

#### 1. PAIN INTENSITY

- ① I have no pain at the moment.
- ® The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- ① The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

## 2. PERSONAL CARE

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

## 3. LIFTING

- ① I can lift heavy weights, without extra pain.
- ® I can lift heavy weights, but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned, for example, on a table.
- ② Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- © I can lift very light weights.
- © I cannot lift or carry anything at all.

## 4. READING

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- © I can read as much as I want with moderate pain in my neck.
- I cannot read as much as I want because of moderate pain in my neck.
- © I cannot read as much as I want because of severe pain in my neck.
- © I cannot read at all.

## 5. HEADACHES

- Thave no headaches at all.
- I have slight headaches which come infrequently.
- © I have moderate headaches which come infrequently.
- ① I have moderate headaches which come frequently.
- $\bigcirc$  I have severe headaches which come frequently.
- © I have headaches almost all the time.

After Vernon & Mior, 1991 Reprinted by permission of the Journal of Manipulative and Physiological Therapeutics

## SIGNATURE:

DATE:

NP1b Pg-1 © 2004 Document Plus Technologies, Inc., Atlanta, GA

Printed In The USA

## 6. CONCENTRATION

- □ I can concentrate fully when I want to with no difficulty.
- © I can concentrate fully when I want to with slight difficulty.
- Thave a fair degree of difficulty in concentrating when I want to.
- ① I have a lot of difficulty in concentrating when I want to.
- © I have a great deal of difficulty in concentrating when I want to.
- ① I cannot concentrate at all.

## 7. WORK

- ① I can do as much work as I want to.
- I can only do my usual work, but no more.
- © I can do most of my usual work, but no more.
- ① I cannot do my usual work.
- © I can hardly do any work at all.
- I cannot do any work at all.

## 8. DRIVING

- © I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- © I can drive my car as long as I want with moderate pain in my neck.
- I cannot drive my car as long as I want because of moderate pain in my neck.
- T can hardly drive at all because of severe pain in my neck.
- © I cannot drive my car at all.

#### 9. SLEEPING

- My sleep is slightly disturbed (less than 1 hour sleepless).
- The My sleep is mildly disturbed (1-2 hours sleepless).
- ① My sleep is moderately disturbed (2-3 hours sleepless).
- My sleep is greatly disturbed (3-5 hours sleepless).
- My sleep is completely disturbed (5-7 hours sleepless).

## 10. RECREATION

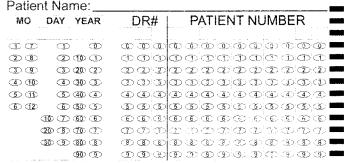
- I am able to engage in all of my recreational activities, with no neck pain at all.
- a lam able to engage in all of my recreational activities, with some pain in my neck.
- 1 am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- I am able to engage in a few of my usual recreational activities because of pain in my neck.
- 1 can hardly do any recreational activities because of pain in my neck.
- The I cannot do any recreational activities at all.

## 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.



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

#### 1. PAIN INTENSITY

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain is severe and does not vary much.

## 2. PERSONAL CARE

- I would not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increases the pain, but I manage not to change my way of doing it.
- Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Because of the pain, I am unable to do some washing and dressing without help.
- 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.
- ® I can lift heavy weights, but it causes extra pain.
- © Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e. g., on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights, at the most.

#### 4. WALKING

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than one mile.
- © Pain prevents me from walking more than 1/2 mile.
- Pain prevents me from walking more than 1/4 mile.
- I can only walk while using a cane or on crutches.
- © 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
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than one hour.
- Depair prevents me from sitting more than 1/2 hour.
- Pain prevents me from sitting more than ten minutes.
- Pain prevents me from sitting at all.

#### 6. STANDING

- I can stand as long as I want without pain.
- I have some pain while standing, but it does not increase with time
- © I cannot stand for longer than one hour without increasing pain.
- cannot stand for longer than 1/2 hour without increasing pain.
- cannot stand for longer than ten minutes without increasing pain.
- I avoid standing, because it increases the pain straight away.
- ® Lavold standing, because it increases the pain straight awa

## 7. SLEEPING

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

## 8. SOCIAL LIFE

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

## 9. TRAVELING

- A l get no pain while traveling
- I get some pain while traveling, but none of my usual forms of travel make it any worse.
- © I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- 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.

© 2004 Document Plus Technologies, Inc., Atlanta, GA Printed In The US.

RO1a Pg-1

EW-224814-3:14

SIGNATURE:

DATE:

## ROLAND-MORRIS ACUTE LOW BACK PAIN **DISABILITY QUESTIONNAIRE**

Please Read: When your back hurts, you may find it difficult to do some of the things you normally do.

This list contains some sentences that people have used to describe themselves when they have back pain. When you read them you may find that some stand out because they describe you today.

As you read the list, think of yourself today. Mark the bubble next to any sentence that describes you today. If the sentence does not describe you, then leave the bubble blank and go on to the next one.

Remember, only mark the sentence if you are sure that it describes you today.

> 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.

Pa	tient I	Name:												
MO	DAY	YEAR	DI	R#			PA	TIE	EN	TN	IUI	MB	ER	
00	①	0	0	0	0	0	0	0	0	0	0	0	0	Ö
23	2	<b>@</b> ①	1		0	1	1	1	1	1	1	1	1	a
39	3	<b>2D</b> 2D	2	D (D)	2	2	2	(2)	2	2	2	2	0	Œ
<b>4 1</b>	4	യാദാ	3	D (D)	3	3	3	3	3	➂	(1)	0	0	J.
(I) (I)	(5)	<b>40 4</b>	4	<b>D (1)</b>	4	4	4	4	4	◑	<b>(1</b> )	<b>(</b>	<b>(1)</b>	<u>(4</u>
<b>© 1</b>	6	<b>®</b> €	<b>(D)</b>	<b>D</b> ( <b>D</b> )	(3)	(3)	(3)	(5)	(5)	ூ	(1)	(5)	$\bigcirc$	Œ
	(D) (D)	௭ ௭	<b>®</b>	<b>D G</b>	<b>6</b>	6	<b>(B)</b>	<b>6</b>	(3)	( <u>6</u> )	(3)	6	(6)	Ĝ
	<b>2</b> 0 (3)	70D (T)	Ø	DD	Ø	7	7	7	7	7	7	7	0	T
	® ®	<b>® ®</b>	<b>®</b>	B B	(3)	(8)	(3)	(8)	3	(3)	(3)	(D)	3	Œ
		<b>90 9</b>	<b>9</b>	9 (D	9	9	9	9	9	(9)	9	(9)	(9)	<b>9</b>

①	I stay at home most of the time because of my back.	My back is painful almost all the time.
<b>②</b>	I change position frequently to try and get my back comfortable.	I find it difficult to turn over in bed because of my back.
3	I walk more slowly than usual because of my back.	My appetite is not very good because of my back.
<b>4</b>	Because of my back I am not doing any of the jobs that I usually do around the house.	I have trouble putting on my socks (or stockings)     because of the pain in my back.
3	Because of my back, I use a handrail to get upstairs.	⊕ I only walk short distances because of my back pain.
<b>6</b>	Because of my back, I lie down to rest more often.	⊕ I sleep less well because of my back.
Œ	Because of my back, I have to hold on to something to get out of any easy chair.	Because of my back pain, I get dressed with help from someone else.
3	Because of my back, I try to get other people to do things for me.	② I sit down for most of the day because of my back.
9	I get dressed more slowly than usual because of my back.	② I avoid heavy jobs around the house because of my back.
100	l only stand up for short periods of time because of my back.	Because of my back pain, I am more irritable and back tempered with people than usual.
℩	Because of my back, I try not to bend or kneel down.	Because of my back, I go upstairs more slowly than usual.
(12)	I find it difficult to get out of a chair because of my back.	

Reprinted with permission of the J.B. Lippincott Company, Philadelphia, PA Appendix 1: Disability Questionnaire from "A Study of the Natural History of a Reliable and Sensitive Measure of Disability in Low Back Pain." Spine 1983; 8(2): 141-4

SIGNATURE:

RM1a Pg-1

© 2004 Document Plus Technologies, Inc., Atlanta, GA Printed In The USA

PLEASE MAKE NO MARKS IN THIS AREA

DATE:



ACCIDENT / I			Patient N	rma'	
ear Patient:			MO DAY		PATIENT NUMBER
his questionnaire will allow omplete it carefully as the i	you to describe your auto	omobile accident in detai	Ⅱ. Please ating and  ①⑦ ③	(D) (D) (D) (D)	
ocumenting your condition.	. THANK YOU.	iodice the doctor in evalu			0000000000
					000000000000
			<b>40 4 6</b>		0000000000
lse a No. 2 pencil to	mark your answers.	When marking in	an Other		<b></b>
ubble please explain i	n the space allowed.	Fill in bubbles com	oletely as   © ® ©		\$\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
ndicated here: O. E	rase changes cleaning	y. Do <b>not fold</b> form.			
			20 3		00000000000
****			<b>_</b>		& & & & & & & & & & & & & & & & & & &
DATE AND TIME	OF ACCIDENT	/ INJURY			
⇒ Date:	Time:	: am/pm	4. If there were lac-		, where were they?
			○ Head	® D Should	ders 🔻 🗇 🗇 Buttocks
DESCRIPTION O	OF ACCIDENT / II	NJURY	○ Neck	⊛ ⊕ Arms	⊕ ⊅ Hips
Automobile Crash Quesi	tionnaire Marked (Skip S	ection B)	○ Upper / Mid Back	® DElbow	s ® 🗇 Thighs
─ Workmen's Compensation	on Accident / Injury		C Lower Back	® ⊕ Forear	rms ® © Knees
	Pedestrian Accident		○ Pelvis	® 🛈 Wrists	® ⊕ Legs
·	O Injury		○ Chest / Rib Cage	® 🛈 Hands	® © Ankles
	_		Abdomen		® © Feet
. What was the caus	se of your accident	/ injury?	Other		
			5. Describe any otl	ner significant	injury:
1 10 1 10 1			0		
			6. Emergency Care		
			a. Did you receiv	e emergency	care? Yes No
' Hescrine in Vour o	wn words what hap				
Describe in your o	, , , , , , , , , , , , , , , , , , , ,	peneu.			
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	pperieu.	b. What type of	emergency car	re did you receive?
		pperieu.	b. What type of		re did you receive?  Brace Neck Collar
					_
			○ Bandages ○ Other	⇒ Splints ⇔	Brace Neck Collar
		ppened.	Other  7. Destination Afte	Splints Splints	Brace
		ppened.	Other  7. Destination Afte a. Where did you	Splints Splints Splints	Brace Neck Collar  ury whom were you driven
		ppened.	Other  7. Destination Afte  a. Where did you  Hospital	Splints Splints  r Accident / Injugo? b. By Home	ury whom were you driven Myself Ambulance
		ppened.	Other  7. Destination Afte  a. Where did you  Hospital School	Splints Splints  r Accident / Injugo? b. By Home	Brace Neck Collar  ury whom were you driven
		ppened.	Other  7. Destination Afte  a. Where did you  Hospital	Splints  r Accident / Injugo? b. By Home	ury whom were you driven Myself Ambulance
		pperieu.	Other  7. Destination Afte  a. Where did you  Hospital School Other	Splints  r Accident / Injugo? b. By Home Work	ury whom were you driven Myself Ambulance Friend Family Membe
		peneu.	Other  7. Destination Afte a. Where did you Hospital School Other  D. HOSPITAL VIS	Splints  r Accident / Injugo? b. By Home Work	ury whom were you driven Myself Ambulance Friend Family Membe Other  CCIDENT / INJURY
			Bandages Other  7. Destination Afte a. Where did you Hospital School Other  D. HOSPITAL VIS 1. When did you ge	r Accident / Injugo? b. By Home Work  IT AFTER Accident / Injugo?	ury whom were you driven Myself Ambulance Friend Family Membe Other  CCIDENT / INJURY al?
IMMEDIATELY A	FTER ACCIDEN		Bandages Other  7. Destination Afte a. Where did you Hospital School Other  D. HOSPITAL VIS 1. When did you get	r Accident / Injugo? b. By Home Work  IT AFTER Accident / Injugo?	ury whom were you driven Myself Ambulance Friend Family Membe Other  CCIDENT / INJURY al? Next Day Days Later
IMMEDIATELY A  Did you lose conso	FTER ACCIDEN	T/INJURY	Bandages Other  7. Destination Afte a. Where did you Hospital School Other  D. HOSPITAL VIS 1. When did you ge	r Accident / Injugo? b. By Home Work  IT AFTER Accident / Injugo?	ury whom were you driven Myself Ambulance Friend Family Membe Other  CCIDENT / INJURY al?
IMMEDIATELY A	FTER ACCIDEN	T/INJURY	Bandages Other  7. Destination Afte a. Where did you Hospital School Other  D. HOSPITAL VIS 1. When did you go Immediately Date	Splints  r Accident / Injugo? b. By Home Work  TAFTER Acto the hospital	ury whom were you driven' Myself Ambulance Friend Family Membe Other  CCIDENT / INJURY ai? Next Day Days Later Other
IMMEDIATELY A  Did you lose conse	FTER ACCIDEN	T/INJURY	Bandages Other  7. Destination Afte a. Where did you Hospital School Other  D. HOSPITAL VIS 1. When did you get	Splints  r Accident / Injugo? b. By Home Work  TAFTER Acto the hospital	ury whom were you driven Myself Ambulance Friend Family Membe Other  CCIDENT / INJURY al? Next Day Days Later
IMMEDIATELY A  Did you lose conso  Yes  How did you feel?	FTER ACCIDEN ciousness? No	T / INJURY	Bandages Other  7. Destination Afte a. Where did you Hospital School Other  D. HOSPITAL VIS 1. When did you go Immediately Date	Splints  r Accident / Injugo? b. By Home Work  TAFTER Acto the hospital	ury whom were you driven Myself Ambulance Friend Family Membe Other  CCIDENT / INJURY al? Next Day Days Later Other
IMMEDIATELY A  Did you lose conso Yes  How did you feel? Confused	FTER ACCIDEN ciousness? No Don't Kn Dazed Dizzy	T/INJURY	Bandages Other  7. Destination Afte a. Where did you Hospital School Other  D. HOSPITAL VIS 1. When did you go Immediately Date Hospital Name:	r Accident / Injugo? b. By Home Work  TAFTER Actor to the hospital	wry whom were you driven? Myself Ambulance Friend Family Membe Other  CCIDENT / INJURY ai? Next Day Days Later Other  Examined By Doctor:
IMMEDIATELY A  Did you lose conso Yes  How did you feel? Confused	FTER ACCIDEN ciousness? No	T / INJURY	Bandages Other  7. Destination Afte a. Where did you Hospital School Other  D. HOSPITAL VIS 1. When did you go Immediately Date	r Accident / Injugo? b. By Home Work  TAFTER Actor to the hospital	wry whom were you driven' Myself Ambulance Friend Family Membe Other  CCIDENT / INJURY ai? Next Day Days Later Other  Examined By Doctor:
MMEDIATELY A  Did you lose conso Yes  How did you feel? Confused Weak	FTER ACCIDEN ciousness? No	T / INJURY  ow  Nervous	Bandages Other  7. Destination Afte a. Where did you Hospital School Other  D. HOSPITAL VIS 1. When did you go Immediately Date  Hospital Name:  Admitted: Yes	r Accident / Injugo? b. By Home Work  TAFTER A to the hospit	wry whom were you driven' Myself Ambulance Friend Family Membe Other  CCIDENT / INJURY al? Next Day Days Later Other Examined By Doctor: Discharged:
IMMEDIATELY A  Did you lose conso Yes  Confused Weak  Where did you imm	FTER ACCIDEN ciousness? No Don't Kn Dazed Dizzy Other mediately develop p	T/INJURY  ow  Nervous	Bandages Other  7. Destination Afte a. Where did you Hospital School Other  D. HOSPITAL VIS 1. When did you go Immediately Date  Hospital Name:  Admitted: Yes  2. If x-rays were tal	Splints  r Accident / Injugo? b. By Home Work  r AFTER A to the hospital Later That Day  No Date D	ury whom were you driven' Myself Ambulance Friend Family Membe Other  CCIDENT / INJURY al? Next Day Days Later Other Examined By Doctor: Discharged: Discharged:
IMMEDIATELY A  Did you lose consection  Yes  How did you feel?  Confused  Weak  Weak  Head	FTER ACCIDEN ciousness? No Don't Kn Dazed Dizzy Other mediately develop p	T / INJURY  ow  Nervous  pain?  B © Buttocks	Bandages Other  7. Destination Afte a. Where did you Hospital School Other  D. HOSPITAL VIS 1. When did you go Immediately Date Hospital Name:  Admitted: Yes  2. If x-rays were tale Head	r Accident / Injugo? b. By Home Work  TAFTER A to the hospit: Later That Day  No Date D  ken, of what be	wry whom were you driven Myself Ambulance Friend Family Membe Other  CCIDENT / INJURY al? Next Day Days Later Other Examined By Doctor: Discharged: Ody part(s)? ders Buttocks
IMMEDIATELY A  Did you lose consection  Yes  Confused Weak  Where did you immediately the section of the sectio	FTER ACCIDEN ciousness? No Don't Kn Dazed Dizzy Other mediately develop p	T / INJURY  ow  Nervous  pain?  B D Buttocks D Hips	Bandages Other  7. Destination Afte a. Where did you Hospital School Other  D. HOSPITAL VIS 1. When did you go Immediately Date Hospital Name:  Admitted: Yes  2. If x-rays were tal Head Neck	Splints  r Accident / Injugo? b. By Home Work  TAFTER AC to the hospit: Later That Day  No Date D  Ken, of what be Should Arms	wry whom were you driven Myself Ambulance Friend Family Membe Other  CCIDENT / INJURY al? Next Day Days Later Other Examined By Doctor: Discharged: Ody part(s)? ders Buttocks Hips
MMEDIATELY A  Did you lose consection  Yes  How did you feel?  Confused  Weak  Weak  Where did you imm  Head  Neck  Upper / Mid Back	FTER ACCIDEN ciousness? No Don't Kn Dazed Dizzy Other mediately develop p	Ow  Nervous  Pain?  Buttocks  Hips Thighs	Bandages Other  7. Destination Afte a. Where did you Hospital School Other  D. HOSPITAL VIS 1. When did you ge Immediately Date Hospital Name:  Admitted: Yes  2. If x-rays were tal Head Neck Upper / Mid Back	r Accident / Injugo? b. By Home Work  TAFTER AC to the hospital Later That Day  No Date D  ken, of what be R D Arms R D Elbow	whom were you driven' Myself Ambulance Friend Family Member Other  CCIDENT / INJURY ai? Next Day Days Later Other Examined By Doctor: Discharged: Ddy part(s)? ders Buttocks R D Hips S Thighs
MMEDIATELY A Did you lose conso Yes  How did you feel? Confused Weak  Where did you imm Head Neck Upper / Mid Back Lower Back	FTER ACCIDEN ciousness? No Don't Kn  Dazed Dizzy Other  mediately develop p	T / INJURY  OW  Nervous  B D Buttocks B D Hips C D Thighs C D Knees	Bandages Other  7. Destination Afte a. Where did you Hospital School Other  D. HOSPITAL VIS 1. When did you ge Immediately Date  Hospital Name:  Admitted: Yes  2. If x-rays were tal Neck Upper / Mid Back Lower Back	Splints  r Accident / Injugo? b. By Home Work  IT AFTER Accident / Injugo? b. By The Home Work  IT AFTER Accident / Injugo?  It AFTER Accident / Injugo.  It AFTER Accident / Injugo.  It AFTE	wry whom were you driven Myself Ambulance Friend Family Membe Other  CCIDENT / INJURY al? Next Day Days Later Other Examined By Doctor:  Discharged: Ody part(s)? ders Buttocks Hips S Hips Thighs Trms Knees
IMMEDIATELY A  Did you lose conso Yes  How did you feel? Confused Weak  Weak  Head Neck Upper / Mid Back Lower Back Pelvis	FTER ACCIDEN ciousness? No Don't Kn  Dazed Dizzy Other  mediately develop p	Ow  Nervous  Buttocks	Bandages Other  7. Destination Afte a. Where did you Hospital School Other  D. HOSPITAL VIS 1. When did you go Immediately Date  Hospital Name:  Admitted: Yes  2. If x-rays were tal Head Neck Upper / Mid Back Lower Back Pelvis	Splints  r Accident / Injugo? b. By Home Work  TAFTER A to the hospital Later That Day  No Date D  Ken, of what be Should Should Should Foreau R C Wrists	wry whom were you driven Myself Ambulance Friend Family Member Other  CCIDENT / INJURY al? Next Day Days Later Other Examined By Doctor: Discharged: D
MMEDIATELY A  Did you lose consolors Yes  How did you feel? Confused Weak  Where did you imm Head Neck Upper / Mid Back Lower Back Pelvis Chest / Rib Cage	FTER ACCIDEN ciousness? No Don't Kn  Dazed Dizzy Other  mediately develop p	Ow  Nervous  Buttocks	Bandages Other  7. Destination Afte a. Where did you Hospital School Other  D. HOSPITAL VIS  1. When did you go Immediately Date  Hospital Name:  Admitted: Yes  2. If x-rays were tal Head Neck Upper / Mid Back Lower Back Pelvis Chest / Rib Cage	Splints  r Accident / Injugo? b. By Home Work  TAFTER A to the hospital Later That Day  No Date D  Ken, of what be Should Should Should Foreau R C Wrists	wry whom were you driven Myself Ambulance Friend Family Membe Other  CCIDENT / INJURY al? Next Day Days Later Other  Examined By Doctor:  Discharged:  Ody part(s)? ders Buttocks Butto
IMMEDIATELY A  I. Did you lose conso Yes  C. How did you feel? Confused Weak  Weak  Weak  Upper / Mid Back Lower Back Pelvis Chest / Rib Cage Abdomen	FTER ACCIDEN ciousness? No Don't Kn  Dazed Dizzy Other  mediately develop p	Ow  Nervous  Buttocks	Bandages Other  7. Destination Afte a. Where did you Hospital School Other  D. HOSPITAL VIS  1. When did you go Immediately Date Hospital Name:  Admitted: Yes Admitted: Yes Upper / Mid Back Upper / Mid Back Lower Back Pelvis Chest / Rib Cage Abdomen	Splints  r Accident / Injugo? b. By Home Work  TAFTER A to the hospital Later That Day  No Date D  Ken, of what be Should Should Should Foreau R C Wrists	wry whom were you driven Myself Ambulance Friend Family Member Other  CCIDENT / INJURY al? Next Day Days Later Other Examined By Doctor: Discharged: D
IMMEDIATELY A  Did you lose conso Yes  Confused Weak  Weak  Head Neck Upper / Mid Back Lower Back Pelvis Chest / Rib Cage	FTER ACCIDEN  ciousness?  No Don't Kn  Dazed Dizzy  Other  mediately develop p  © Shoulders © Arms © Elbows © Forearms © Wrists © Hands	Ow  Nervous  Buttocks	Bandages Other  7. Destination Afte a. Where did you Hospital School Other  D. HOSPITAL VIS  1. When did you go Immediately Date  Hospital Name:  Admitted: Yes  2. If x-rays were tal Head Neck Upper / Mid Back Lower Back Pelvis Chest / Rib Cage	FACCIDENT / Injugo? b. By Home Work  TAFTER A To to the hospital Later That Day  No Date D Ken, of what be R Should R Should R Should R Hands R Hands	wry whom were you driven Myself Ambulance Friend Family Membe Other  CCIDENT / INJURY al? Next Day Days Later Other  Examined By Doctor:  Discharged:  Ody part(s)? ders Buttocks B D Hips S D Thighs Frms B C Ankles

		ISIT AFTER ACCID was performed, of wh		k. Elbows  ® © Strain	® © Sprain	® © Disloc
	> Head	Upper / Mid Back	Chest / Rib Cage	® © Strain	® © Lacerations	® © Contu
	> Neck	○ Lower Back	○ Abdomen	® © Other	3 3 2000,000,00	
_	Other	Comer pack	C Abdomen	as as other		
	Other			I. Forearms		
ł£	a MRI was n	erformed, of what bod	v nart(e)?	® © Strain	® © Sprain	® © Disloc
	a mitti was p ⊃Head		Chest / Rib Cage	® © Fracture	® © Lacerations	® © Contus
		O Upper / Mid Back	-		C C Lacerations	CO COMUS
	> Neck	C Lower Back	○ Abdomen	® © Other		
<u>_</u>	Other			m. Wrists		
1.6	ibat waa tha	diagnasis sixos stabo	haanitala		Consis	© © Dialass
		diagnosis given at the	i nospitai i	® © Strain	® Sprain	® © Disloca
a.	. Head	- 0. "."	- 1 "	® © Fracture	® © Lacerations	® © Contus
	Concussion		Lacerations	® © Other		
	Contusions	Other		, , , , , , , , , , , , , , , , , , ,		
				n. Hands / Fingers		
b	. Jaw			® © Strain	® © Sprain	® Disloca
	○ Strain	○ Sprain	O Dislocation	® ⊕ Fracture		® © Contus
	Fracture	○ Whiplash	○ Lacerations	® © Other		
	Contusions	Other				
				o. Buttocks		
C.	. Neck			® © Strain	🗷 🗅 Sprain	® © Lacera
	Strain	Sprain	Dislocation	⊕ ⊕ Contusions	® © Other	
	Fracture	Whiplash	Disc Injury			
	<ul> <li>Lacerations</li> </ul>	Contusions		p. Hips		
	Other			® © Strain	® © Sprain	® © Disloca
		Marie		® © Fracture	⊕	® © Contus
d	. Upper / Mid	dle Back		® Other		
	○ Strain	○ Sprain	O Dislocation			
	○ Fracture	O Disc Injury	○ Lacerations	q. Thighs		
	Contusions	Other		® © Strain	® © Sprain	® © Disloca
	OGNICONO	O O O O O O O O O O O O O O O O O O O		® © Fracture	® © Lacerations	® © Contus
_	. Lower Back	,		® © Other	C Lacciations	D D Oomas
	Strain	○ Sprain	<ul> <li>Dislocation</li> </ul>	Co Co Other		
		•	: :	r. Knees	<del></del>	
	○ Fracture	Olisc Injury	○ Lacerations		@ Cornin	⊕ ⊕ Disloca
	O Contusions	Other Other		® © Strain	® © Sprain	
	<b>1</b> 5. 1 1			® © Fracture	® © Lacerations	® © Contus
T.	Pelvis			® © Other		
	○ Strain	○ Sprain	Dislocation			
	○ Fracture	<ul> <li>Lacerations</li> </ul>	○ Contusions	s. Legs		
	Other			® © Strain	® © Sprain	® © Disloca
					® © Lacerations	® © Contus
g	. Chest / Rib	Cage		® © Other		
	Strain	Sprain	Dislocation			
	Fracture	Lacerations	○ Contusions	t. Ankles		
	Other			® © Strain	® © Sprain	® © Disloca
				® ⊕ Fracture	® © Lacerations	® © Contus
h	. Abdomen			® © Other		
	○ Strain	○ Lacerations	○ Contusions			
	Other			u. Feet / Toes		
L				® © Strain	® © Sprain	® © Disloca
i	Shoulders			® © Fracture	® © Lacerations	® © Contus
**	® © Strain	® © Sprain	® Dislocation	® © Other		
	® © Fracture		® © Contusions	CO COUNTRI		
		CO CO Lacerations	A COMUSIONS	v. Other		
	® © Other _					
•	A			○ Strain	○ Sprain	Dislocation
j.	Arms			○ Fracture	<ul> <li>Lacerations</li> </ul>	Contusion
	® © Strain	® © Sprain	® © Dislocation	w Docariha ani: a:	dditional diamas:	e alvon:
	® © Fracture		® © Contusions	w. Describe any a	uuttional diagnosi	s giveri:
	® Other		i			

	<u>SII AFTER I</u>	<u>ACCIDENT</u>	/ INJURY	i. Shoulders			
6. What treatment w	vas administer	ed at the hos	spital?	® ⊕ Pain ® ⊙	Stiffness		® ⊥ Tinglir
Oral Medication	Sutures	Splint	○ Collar	® © Other			
Injection	Ice Packs	•	Support				
Topical Antiseptics			Surgery	i. Arms			
○ Bandages	Other			•	Stiffness     ■	®   Numbness	æ: Œ Tinalir
and the state of t				® © Other			<u>.</u>
7. Instructions Give	n When Disch	arged From	Hospital				
a. Were you told				k. Elbows			
General Practiti		ractor 🔾	Neurologist		T Stiffness	® © Numbness	Tinglin
Physical Therap			Internist	® © Other	<i>-</i>	<u> </u>	
General Surgeo			THO THOU				
-		Surgeon		I. Forearms			
Other					Ctiffnoor	® ① Numbness	Tinalia
b. What recomme	andations war	o mado?		***************************************			CEC Tingin
			Oh manustian	R C Uner		and a second	
No Further Care		-up Instructions	i	m. Wrists			
	e		j j		000		an money
Time Off Work	Other				D Stiffness	® © Numbness	ROCL Lingili
		10		® © Other			
c. Were medication	•						
○ Pain ○ Anti-i	nflammatory $\bigcirc$ /	Antibiotic O	Vervousness	n. Hands / Finge			
Other		e element				® © Numbness	
FOLLOWING T	HE ACCIDE	NT / IN IUD	<b>V</b>	® © Other			
FOLLOWING TI							
<ol> <li>How much later of</li> </ol>			-	o. Buttocks			
Immediately	Hours C Tha	it Evening 🔝	Next Morning	® © Pain ®	□ Stiffness	® ⊕ Numbness	குட Tinglir
○ Days	⇒Week ⇔ Mor	nth		® © Other			
2. What additional s	symptoms dev	eloped?		p. Hips			
a. Head						® D Numbness	
○ Pain	Stiffness	○ Numbness	○ Tingling	® © Other			
Other							
				q. Thighs			
b. Jaw							
Pain C	⊃ Stiffness :	○ Numbness	○ Tingling	® © Other			
Other							
				r. Knees			
c. Neck				® © Pain ®	Stiffness	® © Numbness	🔞 💷 Tinglir
○ Pain	⊃ Stiffness ⊂	Numbness	○ Tingling	® © Other	TITLE THE THE PARTY OF THE PART	NAMES AND ADDRESS OF THE OWNER, WHEN THE	
Other							
				s. Legs			
d. Upper / Middle	Back			®©Pain ®	Stiffness	® © Numbness	√8 ∴ Tinglir
d. Upper / Middle		Numbness	○ Tingling		Stiffness	® © Numbness	√8°04. Tinglir
O Pain C		○ Numbness	○ Tingling	® © Pain ® C	Stiffness	® © Numbness	√8 :- (L. Tinglir
		○ Numbness	○ Tingling	® © Pain ® © ® © Other	D Stiffness	⊕ © Numbness	√8 ⊝⊈ Tinglir
○ Pain ○ ○ Other		○ Numbness	○ Tingling	® © Pain ® C		® © Numbness	V
OPain Other  e. Lower Back	Stiffness	n n n na n		® © Pain ® ©  ® © Other  t. Ankles  ® © Pain ® ©			V
Pain Other  e. Lower Back Pain	Stiffness	○ Numbness ○ Numbness	○ Tingling ○ Tingling	® © Pain ® © Other			V
Other  e. Lower Back	Stiffness	n n n na n		B D Pain B C D Other  t. Ankles D Pain B C D Other			V
Pain Other  e. Lower Back Pain Other	Stiffness	n n n na n		Pain Pain Control Other  t. Ankles Pain Pain Pain Control Other  u. Feet / Toes	D Stiffness	® ⊕ Numbness	® ⊈ Tinglir
Pain Other  e. Lower Back Pain Other  f. Pelvis	Stiffness	○ Numbness	○ Tingling	B D Pain B C B D Other  t. Ankles B D Pain B C B D Other  u. Feet / Toes B D Pain B C	D Stiffness		® ⊈ Tinglir
Pain Other  e. Lower Back Pain Other  f. Pelvis Pain	Stiffness	n n n na n		Pain Pain Control Other  t. Ankles Pain Pain Pain Control Other  u. Feet / Toes	D Stiffness	® ⊕ Numbness	® ⊈ Tinglir
Pain Other  e. Lower Back Pain Other  f. Pelvis	Stiffness	○ Numbness	○ Tingling	R D Pain R C R D Other  t. Ankles R D Pain R C R D Other  u. Feet / Toes R D Pain R C D Other	D Stiffness	® ⊕ Numbness	® ⊈ Tinglir
Pain Other  e. Lower Back Pain Other  f. Pelvis Pain Other	> Stiffness	○ Numbness	○ Tingling	B D Pain B C B D Other  t. Ankles B D Pain B C B D Other  u. Feet / Toes B D Pain B C	D Stiffness	® ⊕ Numbness	® ⊈ Tinglir
Pain Other  e. Lower Back Pain Other  f. Pelvis Pain Other  g. Chest / Rib Ca	> Stiffness	○ Numbness	<ul><li>Tingling</li><li>Tingling</li></ul>	Pain Poin Poin Poin Poin Poin Poin Poin Po	D Stiffness  □ Stiffness	® ⊕ Numbness  ® ⊕ Numbness	⊛ ⊈ Tinglir ு ட Tinglir
Pain Other  e. Lower Back Pain Other  f. Pelvis Pain Other  g. Chest / Rib Ca	> Stiffness	○ Numbness	○ Tingling	Pain Poin Poin Poin Poin Poin Poin Poin Po	D Stiffness  □ Stiffness  lent / injury	® © Numbness  ® © Numbness  have you suffe	® ⊈ Tinglir ⇔ L Tinglir
Pain Other  e. Lower Back Pain Other  f. Pelvis Pain Other  g. Chest / Rib Ca	> Stiffness	○ Numbness	<ul><li>Tingling</li><li>Tingling</li></ul>	** Pain ** Other  ** C. Other  ** T. Ankles  ** D. Pain ** Other  ** U. Feet / Toes  ** D. Pain ** Other  ** U. Other  ** V. Other  ** V. Other  ** V. Other  ** Since your accidence of Blurred Vision	D Stiffness  □ Stiffness  lent / injury  □ Chest Pai	® © Numbness  R © Numbness  have you suffering Naus	Tinglir Tinglir Tinglir Tred from?
Pain Other  e. Lower Back Pain Other  f. Pelvis Pain Other  g. Chest / Rib Ca Pain Other	> Stiffness	○ Numbness	<ul><li>Tingling</li><li>Tingling</li></ul>	Pain Poin Poin Poin Poin Poin Poin Poin Po	D Stiffness  □ Stiffness  lent / injury  □ Chest Pai	® © Numbness  ® © Numbness  have you suffe	Tinglir Tinglir Tinglir Tred from?
Pain Other  e. Lower Back Pain Other  f. Pelvis Pain Other  g. Chest / Rib Ca Pain	> Stiffness	○ Numbness	<ul><li>Tingling</li><li>Tingling</li></ul>	** Pain ** Other  ** C. Other  ** T. Ankles  ** D. Pain ** Other  ** U. Feet / Toes  ** D. Pain ** Other  ** U. Other  ** V. Other  ** V. Other  ** V. Other  ** Since your accidence of Blurred Vision	D Stiffness  □ Stiffness  lent / injury  □ Chest Pai	Numbness  Numbness  Numbness  Nave you sufferin  Nauser  Reathing  Vomit	Tinglir Tinglir Tinglir Tred from?
Pain Other  e. Lower Back Pain Other  f. Pelvis Pain Other  g. Chest / Rib Ca Pain Other  h. Abdomen	> Stiffness > Stiffness  > Stiffness  > Stiffness	○ Numbness	<ul><li>Tingling</li><li>Tingling</li></ul>	T. Ankles  T. Ankles  T. Ankles  T. Pain  T. Other  T. Ankles  T. Pain  T. Other  T. O	□ Stiffness □ Stiffness  lent / injury	Numbness  Numbness  Numbness  Nave you sufferin  Nause Breathing Vomitens  Frequence	Tinglir  Tinglir  Tred from?

\_\_

E. FOLLOWING	THE ACCIDENT/I	NJURY (Continued)	f. General Surgeon O Name:	- <u>-</u>
4. Additionally ha	ve you experienced	any of the following?	Diagnosis And Treatment Recommendation:	· · · · · · · · · · · · · · · · · · ·
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	g. Plastic Surgeon  O Name:	
Other		○ Weight Loss	Diagnosis And Treatment Recommendation:	
result of this ac		owing areas as a		
Other		Necreational Activities		
C Have very mine	and supply also as a finite of	and don't link unt?	h. Psychologist OName:	
<ul><li>Missed No Work</li><li>Missed Work From</li></ul>		Climited Work Activity	Diagnosis And Treatment Recommendation:	
Other				· · · <u></u>
7. Did you self tre	eat your symptoms?			
	○ Bed Rest ○ Ov	er-The-Counter Medication	i. Other Name:	Гуре:
Other			Diagnosis And Treatment Recommendation:	
	nedical care elsewhe	re?	_	
a. General Prac	ctitioner  Name:			
Diagnosis An	d Treatment Recommenda	tion:	The state of the s	
<b>b. Internist</b> O Diagnosis An	○ Name: d Treatment Recommenda	tion:	Other  Other  Other  Other	sultation
			<ul><li>Persisting Complaints</li><li>Other</li></ul>	
		<u>,</u>	F. INSURANCE / ATTORNEY INFORMATI	
			1. Have you contacted an insurance adjuster	Yes No
c. Chiropractor			or representative regarding this claim?	<b>(N)</b>
Diagnosis An	d Treatment Recommenda	tion:	Company:	
			Adjuster:	
			Olatina #	
			Claim #:	
			2. Have you engaged services of an attorney?	Ý (N)
d. Neurologist	○ Name:		Attorney:	
Diagnosis An	d Treatment Recommenda	tion:		ļ
			Address:	
-			City: State: Zip: Phone:	
e. Orthopedist	◯ Name:	Source 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	3. Have you filed an accident / injury report?	O OL
•	d Treatment Recommenda	tion:	4. Have you filed for insurance benefits?	(Y) (N)
O Diagnosis All	o realment Necommenta	uon.	_ \	EW-227667-3:
			Patient's Or Guardian Signature: Date:	
			dient's Or Quartian Signature. Date.	

■ © 2005 Document Plus Technologies, Inc., Atlanta, GA

Printed In The USA 493545

PLEASE MAKE NO MARKS IN THIS AREA