History of Symptoms Name_____ Date_____

What is your major complaint?

① _____

_____

② _____

_____

③ _____

_____

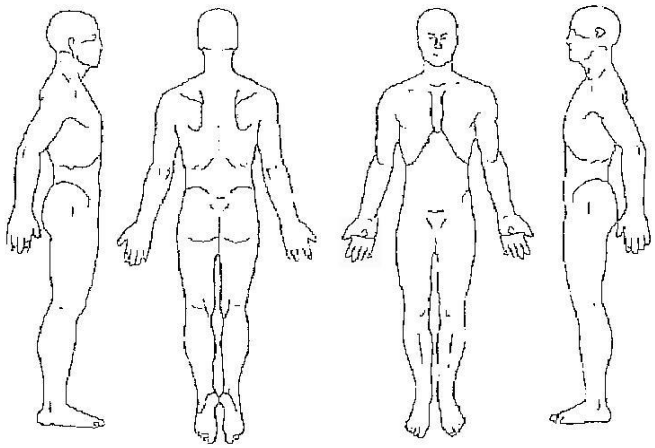
④ _____

_____

⑤_____

_____

Indicate where you have pain or other symptoms:



Indicate the average intensity of your symptoms:

None Unbearable

① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

How did you injure yourself? _____

How long have you had this condition? _____

Have you had similar conditions in the past? Explain: _____

_____

How often do you experience your symptoms?

- ☐ Constantly (Most of the time)
- ☐ Frequently (½ to ¾ of the time)
- ☐ Occasionally (¼ to ½ of the time)
- ☐ Intermittently (up to ½ of the time)

What types of pain are you experiencing?

- ☐ Dull ☐ Throbbing ☐ Spasm ☐ Sharp ☐ Burning ☐ Stinging ☐ Aching
- ☐ Numbing ☐ Shooting ☐ Cutting ☐ Tingling ☐ Pounding ☐ Cramping ☐ Other_____

Indicate other areas that your pain radiates to:

- ☐ Head ☐ Neck ☐ Shoulders ☐ Arms ☐ Hands
- ☐ Hips ☐ Legs ☐ Feet ☐ Other_____

Indicate actions which bring on or aggravate your symptoms:

- ☐ Bending Forward ☐ Bending Back ☐ Bending Left ☐ Bending Right ☐ Standing ☐ Sitting
- ☐ Twisting Left ☐ Twisting Right ☐ Lifting ☐ Straining ☐ Waking Up ☐ Going to Sleep

Indicate actions which relieve your symptoms:

- ☐ Bending Forward ☐ Bending Back ☐ Bending Left ☐ Bending Right ☐ Standing ☐ Sitting
- ☐ Twisting Left ☐ Twisting Right ☐ Lifting ☐ Straining ☐ Waking Up ☐ Going to Sleep

Is this condition getting progressively worse? ☐ Yes ☐ No

How much has pain interfered with your normal activities?

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

List some of the things you are unable to do because of pain: _____

_____

Is there anything else you feel the Doctor should know about your symptoms? _____

_____

Accident History Name_____ Date_____

Is this a Motor Vehicle Accident Case? ☐ Yes ☐ No Is this a Worker's Compensation Case? ☐ Yes ☐ No

Date of injury: _____ Time: _____ AM/PM

Enter a full description of the accident or injury below (you may draw a picture):

Automobile Accident Information

Where were you seated? ☐ Driver ☐ Passenger ☐ L Rear ☐ R Rear Did you have a seat belt on? ☐ Yes ☐ No

Make, model, and year of your car:_____ Other car:_____ Who hit who?_____

Visibility at time of accident: ☐ Poor ☐ Fair ☐ Good

Road conditions at time of accident: ☐ Icy ☐ Wet ☐ Sandy ☐ Dark ☐ Clean & Dry

Your car's speed:_____ Other car's speed:_____ Approximate damage done to your car: $_____

Where was your car struck? ☐ L Front ☐ R Front ☐ L Rear ☐ R Rear ☐ Rear-ended ☐ Head On

Did you see the accident coming? ☐ Yes ☐ No Did you brace for impact? ☐ Yes ☐ No

What was the position of your headrest at the time of the accident?

☐ Even with top of head ☐ Even with bottom of head ☐ Middle of neck

What was the direction of your head at the time of the accident?

☐ Facing straight forward ☐ Turned to the right ☐ Turned to the left

Did your body strike the inside of your vehicle? ☐ Yes ☐ No If yes, explain:_____

Were you knocked unconscious? ☐ Yes ☐ No Did you get any bleeding cuts? ☐ Yes ☐ No Bruises? ☐ Yes ☐ No

Additional Accident Information

Was your injury reported to the police? ☐ Yes ☐ No Was an accident report filled out? ☐ Yes ☐ No

Where did you go after the accident? ☐Home ☐Work ☐Private Doctor ☐Hospital ER

Did you go by ambulance? ☐ Yes ☐ No Which Doctor/Hospital did you visit?_____

Were X-Rays done? ☐ Yes ☐ No Body parts x-rayed: _____

Was lab work done? ☐ Yes ☐ No What lab work? _____

Treatments you received? ☐ Cervical Collar ☐ Ice ☐ Other: _____

List any other doctor(s) seen prior to your first visit to this office(for this accident):_____

Did you miss any time form work? ☐ Yes ☐ No How much? _____

Check off your symptoms right after and a few days following the accident:

☐Headache ☐Neck pain/stiffness ☐Dizziness ☐Nausea ☐Confusion ☐Chest pain ☐Low back pain ☐Mid back pain
☐Fatigue ☐Tension ☐Irritability ☐Ringing in ears ☐Loss of smell ☐Pain behind eyes ☐Fainting ☐Nervousness
☐ Loss of taste ☐Toe numbness ☐Cold hands/feet ☐Depression ☐Shortness of breath ☐Sleeping problems

☐Other_____

Prior Symptom History

Prior Similar Symptoms:
- ☐ I have not had prior symptoms similar to my current complaints.
- ☐ My current complaints did exist before, but have not been bothering me.
- ☐ My current complaints already existed and were worsened.

Explain: _____

Has your history contributed to your current symptoms? ☐ Yes ☐ No

If yes, explain: _____

Is there anything about your accident you feel was left out? _____