Instructions:

Please write neatly on each page

Fill out each form as completely as possible

Fill out each page for each person that will be receiving treatment

Put the name of the patient at the top of each page

The patient (or guardian, if the patient is under 18 years old) should sign where indicated

On the symptom history page, print one page for each symptom (neck pain, low back pain, left shoulder pain, right knee pain, etc.) and answer each question for each symptom

Name: _____

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Patient Health History

1. Past Health History:

A. Please indicate if you have a history of any of the following:

□ Anticoagulant use □ Heart problems/high blood pressure/chest pain □ Bleeding problems
□ Lung problems/shortness of breath □ Cancer □ Diabetes □ Psychiatric disorders
□ Bipolar disorder □ Major depression □ Schizophrenia □ Stroke/TIA's □ Other _____
□ None of the above

B. Surgeries: ☐Yes ☐No If yes please explain_____

_____

_____

_____

Use space below or on back if needed

C. Medication: ☐Yes ☐No If yes please explain_____

D. Previous Injury or Trauma:☐Yes ☐No If yes please explain (Include Auto Accidents, Work injuries, Falls, Sports injuries and other significant injuries)

Date of Injury	Description of Injury and Treatment Received	Any Residual Problems

Have you ever broken any bones (Fractures)?: ☐Yes ☐No If yes please explain

_____

E. Allergies: ☐Yes ☐No If yes please explain_____

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery Outcome

_____

_____

_____

_____

Use space below or on back if needed

Name: _____

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2. Family Health History:

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases
□ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes
□ Adopted/Unknown □ Other _____ □ None of the above

Deaths in immediate family:

_____ _____

Cause of parents or siblings death Age at death

_____

_____

_____

3. Social and Occupational History:

A. Job description:

_____

B. Work schedule:

_____

C. Recreational activities:

_____

D. Lifestyle (diet , hobbies, level of exercise, alcohol, tobacco and drug use):

_____

E. Sports: ☐Yes ☐No If yes please explain

_____

I have read the above information and certify it to be true and correct to the best of my knowledge.

_____ _____

Patient Signature (guardian if under 18) Date

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Review of Systems

Name: _____

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs
□ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat
□ Other _____ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures
□ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo
□ Loss of sense of smell □ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia
□ Constipation □ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease
□ Bloody or black tarry stools □ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn
□ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____
□ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery
□ Joint surgery □ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____
□ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations
□ Schizophrenia □ Psychiatric hospitalizations □ Other _____ □ None of the above

_____ _____
Patient Signature (guardian if under 18) Date

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Motor Vehicle Accident Injury Questionnaire

Name: _____

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1. Were you wearing a seatbelt? □ **Yes** □ **No** □ **I don't remember**
- What type? □ **Lap** □ **Lap and Shoulder** □ **Car Seat** □ **Booster Seat**

2. What was your position in the car? □ **Driver** □ **Front Passenger** □ **Rear Passenger**

3. What type of vehicle were you in? (year, make, model) _____

4. What speed was your car traveling? _____ mph □ stopped □ I don't know

5. Were you hit on the …… First Impact → □**Front** □**Back** □**Left** □**Right** □ **I don't remember**
Second Impact → □**Front** □**Back** □**Left** □**Right** □ **I don't remember** □**No 2nd Impact**

6. What type of vehicle was the other car? (year, make, model)
_____

7. What speed was the other car traveling? _____ mph □ stopped □ I don't know

8. Did your seat have a Headrest? □ **Yes** □ **No** □ **I don't remember**
- Was it adjusted….. □ **Low** □ **Middle** □ **High** □ **I don't remember**
- Was your head against the headrest at the time of the accident? □ **Yes** □ **No** □ **I don't remember**

9. At the time of impact, were you?
□ **Surprised** □ **Aware it was going to happen** □ **Aware it was going to happen and braced for impact**

10. Position of your **HEAD** at the time of impact?
□ **Looking Straight** □ **Looking Down** □ **Looking Up** □ **Turned Left** □ **Turned Right** □ **I don't remember**

11. Was your car smaller than the other car? □ **Yes** □ **No** □ **I don't remember**

12. How soon after the accident did you feel pain?
□ **Immediately** □ **30 minutes or less** □ **_____ Hours** □ **_____ Days** □ **Not Sure**

13. Road Condition was: □ **Dry** □ **Damp** □ **Wet** □ **Snow** □ **Ice** □ **Other**:_____

14. Were Brakes applied at impact? □ **Yes** □ **No** □ **Unknown**

15. Did the Air Bag deploy? □ **Yes** □ **No** → Were you? □ **Struck** □ **Burned**

16. Did the car have automatic transmission? □ **Yes** □ **No** □ **Unknown**

17. If this was a rear-end collision, did your car have a receiving hitch (tow-bar)?
□ **Yes** □ **No** □ **Not a rear-end collision**

18. Were you wearing? □ **Hat** □ **Glasses** □ **No** → Were they still on after the accident? □ **Yes** □ **No** □ **I don't remember**

19. Did your seat break or bend? □ **Yes** □ **No** □ **Unknown**

20. Did you strike anything inside the vehicle at the time of impact? □ **Yes** □ **No** □ **Unknown** If "YES", specify what part of your body struck what: (i.e. head, chest, chin, shoulder, knee, etc.)

□ Steering Wheel	□ Windshield
□ Dashboard	□ Roof
□ Left Side Door	□ Right Side Door
□ Left Window	□ Right Window
□ Other	

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Name: _____

21. Were you rendered unconscious as a result of the accident? ☐ **Yes** ☐ **No** ☐ **Unknown**

22. Immediately following the accident, how did you feel? (Circle all that apply) **Dizzy** / **Dazed** / **Weak** / **Upset** / **Disoriented** / **Nervous** / **Nauseous** / **Other**: _____

23. Since the accident, have you been experiencing any of the following symptoms? (check all that apply)

- ☐ **Dizziness** – How often? (0-100% of day)_____%
- ☐ **Loss of Range of Motion** – What area of your body?_____
- ☐ **Visual Disturbance** – Left Side / Right Side - How often? (0-100% of day)_____%
- ☐ **Anxiety** - How often? (0-100% of day)_____%
- ☐ **Depression** - How often? (0-100% of day)_____%
- ☐ **Sleep Disturbance <u>(Unless the accident happened today)</u>**

24. Where did you go after the accident? ☐ **Home** ☐ **Work** ☐ **Hospital** ☐ **Other**_____

- How did you get there? ☐ **Drove Self** ☐ **Ambulance** ☐ **Taxi** ☐ **Friend** / **Family Member**
- If you went to the Hospital, which one? _____
- At HOSPITAL was an **exam** done? ☐ **Yes** ☐ **No**
- **X-rays** done? ☐ **Yes** ☐ **No** → Did you have any fractured bones? ☐ **Yes** ☐ **No**
  - Which bones were fractured? _____

25. Since the accident have you seen any other doctors for this injury?

☐ **Yes** -- If YES, **who**?_____

☐**No**

26. Are you planning to see your primary doctor (so we can send a report)?

☐**Yes** -- If YES, **who**?_____

☐**No**

_____ _____

Patient Signature (guardian if under 18) Date

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Name: _____

Duties Under Duress and Loss of Enjoyment Summary

These are things that I can't do or have trouble doing, but I **HAVE** to do		These are things that I can't do or have trouble doing, but I **LIKE** to do

Work Job Description: _____

☐	Lifting	☐
☐	Bending	☐
☐	Sitting	☐
☐	Walking	☐
☐	Computer Duties	☐
☐	Other: _____	☐

Studies/School

☐	Lifting	☐
☐	Bending	☐
☐	Sitting	☐
☐	Walking	☐
☐	Computer Duties	☐
☐	Studying	☐
☐	Other: _____	☐

Domestic Duties

☐	Vacuuming	☐
☐	Taking Care of Kids	☐
☐	Cleaning	☐
☐	Preparing Meals	☐
☐	Other: _____	☐

Household Duties

☐	Yardwork	☐
☐	Transportation	☐
☐	Shopping	☐
☐	Taking Out Trash	☐
☐	Other: _____	☐

Sports Sport Description: _____

	Social	☐
	Competitive	☐
	Regional	☐
	Other: _____	☐

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Name: _____ (Print one page for each symptom)

SYMPTOM HISTORY FORM

Symptom _____ (for example: neck pain, upper back pain, mid back pain, low back pain, right shoulder pain, left knee pain, headaches)

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin? _____
    - Did you have this symptom before this motor vehicle collision? Yes/No
        - If so, what was the intensity (1-10 w/10 the worst) and frequency? ____
- What makes the symptom worse? (circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, other (please describe): _____, nothing
- What makes the symptom better? (circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, Other (please describe): _____, nothing
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - Morning Afternoon Evening Night Unaffected by time of day