

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: _____

Clinica Real LLC, Chiropractic 420 E. Southern Ave., Suite #101 Mesa, AZ 85204 (480) 223-9595

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

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: _____

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.)

<input type="checkbox"/> Steering Wheel	<input type="checkbox"/> Windshield
<input type="checkbox"/> Dashboard	<input type="checkbox"/> Roof
<input type="checkbox"/> Left Side Door	<input type="checkbox"/> Right Side Door
<input type="checkbox"/> Left Window	<input type="checkbox"/> Right Window
<input type="checkbox"/> 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 (Unless the accident happened today)**

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

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: _____

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