



**New Patient Form**

Print Name \_\_\_\_\_ Date \_\_\_\_\_

Email \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell # \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

Your Occupation \_\_\_\_\_ Work Duties \_\_\_\_\_

How did you hear about the office? \_\_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Cell # \_\_\_\_\_ Home # \_\_\_\_\_

**Insurance Information**

Insured's Name \_\_\_\_\_

Insured's Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Relation to Patient \_\_\_\_\_

Marital Status    Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

**Sex**                    Male \_\_\_\_\_                    Female \_\_\_\_\_

**Race**                    American Indian or Alaska Native \_\_\_\_\_ Black or African American \_\_\_\_\_

White \_\_\_\_\_ Hispanic or Latino \_\_\_\_\_ Asian \_\_\_\_\_ Not Provided \_\_\_\_\_

**Ethnicity**                    Not Hispanic or Latino \_\_\_\_\_                    Hispanic or Latino \_\_\_\_\_

**Smoking**                    Current Every Day Smoker \_\_\_\_\_ Current Some Day Smoker \_\_\_\_\_

Former Smoker (> than 100 Cigarettes in Lifetime) \_\_\_\_\_ Never Smoked \_\_\_\_\_



Name \_\_\_\_\_ Date \_\_\_\_\_

**Medical History – Section 1**

Height \_\_\_\_\_ Weight \_\_\_\_\_

Have you ever been to a Chiropractor before? YES \_\_\_\_\_ NO \_\_\_\_\_

If YES Doctor's Name: \_\_\_\_\_

Date of last Chiropractic visit: \_\_\_\_\_ Reason for Care: \_\_\_\_\_

Who is your Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

List any Conditions you are currently being treated for: \_\_\_\_\_

FEMALES ONLY: Is there a possibility you are pregnant? YES \_\_\_\_\_ NO \_\_\_\_\_

Have you had a DEXA Scan? YES \_\_\_\_\_ NO \_\_\_\_\_ If so, when? \_\_\_\_\_

Have you had a Vitamin D Test? YES \_\_\_\_\_ NO \_\_\_\_\_

**Please check if you have had or currently have**

Fractures \_\_\_\_\_ Osteopenia \_\_\_\_\_ Osteoporosis \_\_\_\_\_

Heart Problems \_\_\_\_\_ Cancer \_\_\_\_\_ Blood Disorder/Clotting \_\_\_\_\_

**If you have had the following, or if you suffer from the following, please Check ✓**

Condition, Symptom or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>
Leg/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Other joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>

Condition, Symptom or Problem	Constantly or Frequently	Sometimes or Occasionally
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Vision Changes	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Female Problems	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Problem	<input type="checkbox"/>	<input type="checkbox"/>



Name \_\_\_\_\_ Date \_\_\_\_\_

**Medical History – Section 2**

<b>Medications</b>	<b>YES _____</b>	<b>NO _____</b>	<b>If YES, please list current medication</b>
1.	_____	_____	5. _____
2.	_____	_____	6. _____
3.	_____	_____	7. _____
4.	_____	_____	8. _____

<b>Drug Allergies</b>	<b>YES _____</b>	<b>NO _____</b>	<b>If YES, please list below</b>
1.	_____	_____	2. _____

<b>Surgeries</b>	<b>YES _____</b>	<b>NO _____</b>	<b>If YES, please list type and date</b>
1.	_____	_____	4. _____
2.	_____	_____	5. _____
3.	_____	_____	6. _____

<b>Past Accidents</b>	<b>YES _____</b>	<b>NO _____</b>	<b>If YES, please list type and date</b>
1.	_____	_____	3. _____
2.	_____	_____	4. _____

**Other Medical History** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

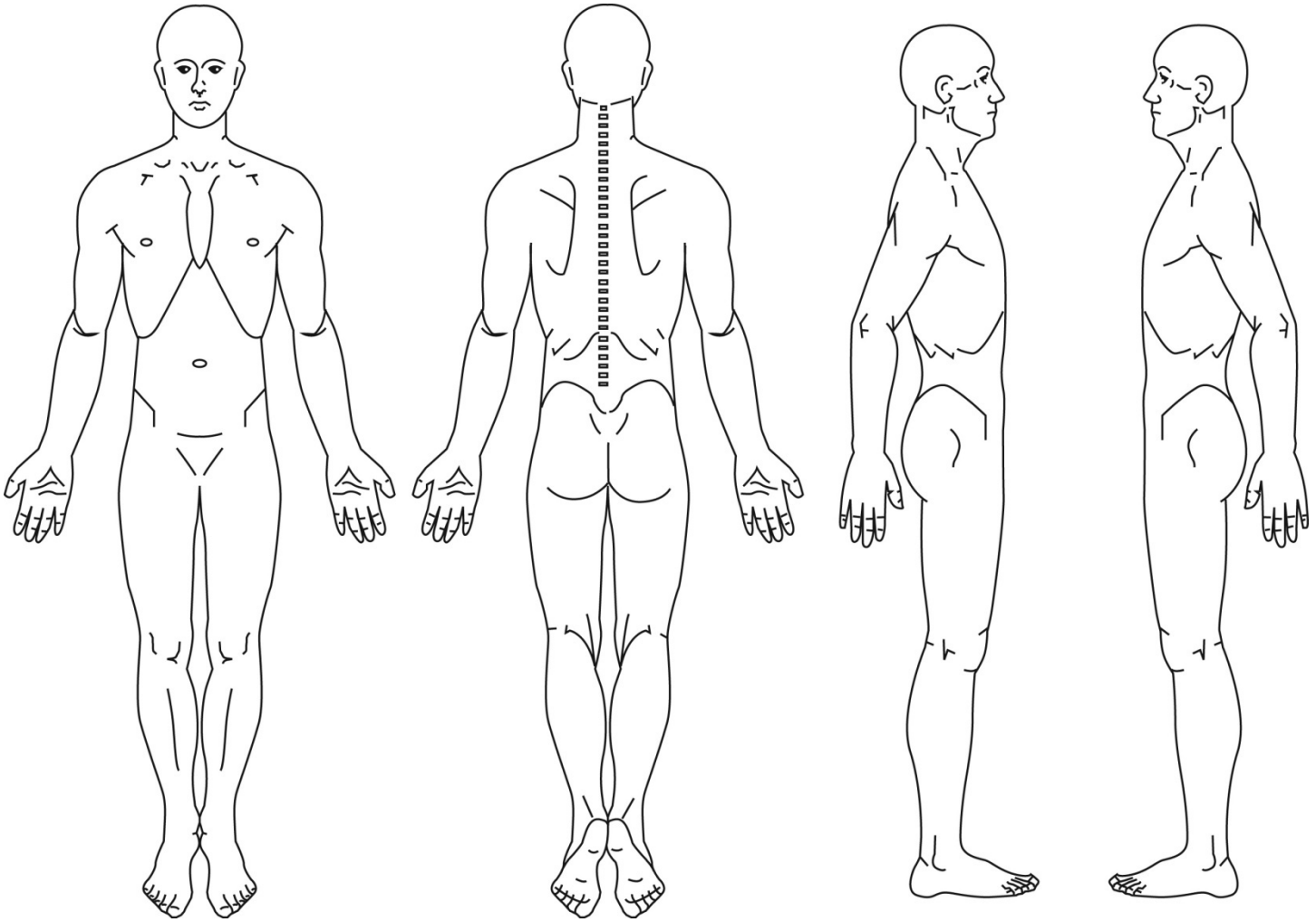
\_\_\_\_\_



Name \_\_\_\_\_ Date \_\_\_\_\_

### Pain Diagram

Please mark the diagram according to where you experience your symptoms and pain.



**Primary Reason for Seeking Chiropractic Care** \_\_\_\_\_

Notes \_\_\_\_\_

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### Health Questionnaire – Page 1

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE CIRCLE YOUR ANSWERS**

1. In general, would you say your health is?

\_\_\_\_\_ 1-Excellent          2-Very Good          3-Good          4-Fair          5-Poor \_\_\_\_\_

2. Compared to one year ago, how would you rate your health in general?

\_\_\_\_\_ 1- Much better    2-Somewhat better    3-About the same    4-Somewhat worse    5-Much worse \_\_\_\_\_

**Does your health limit you in these activities? If so, how much?**

	Yes, limited a lot	Yes, limited a little	No, not limited
3. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports.	1	2	3
4. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf.	1	2	3
5. Lifting or carrying groceries.	1	2	3
6. Climbing several flights of stairs.	1	2	3
7. Climbing one flight of stairs.	1	2	3
8. Bending, kneeling or stooping.	1	2	3
9. Walking more than a mile.	1	2	3
10. Walking several blocks.	1	2	3
11. Walking one block.	1	2	3
12. Bathing or dressing yourself.	1	2	3

**During the past 4 weeks, have you had any of the following problems with your work or daily activities as a result of your physical health?**

13. Cut down the amount of time you spent on work or other activities.	1-Yes	2-No
14. Accomplished less than you would like?	1-Yes	2-No
15. Were limited in the kind of work or other activities.	1-Yes	2-No
16. Had difficulty performing the work or other activities.	1-Yes	2-No

**During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?**

17. Cut down the amount of time you spent on work or other activities.	1-Yes	2-No
18. Accomplished less work than you would like.	1-Yes	2-No
19. Didn't do work or other activities as carefully as usual.	1-Yes	2-No

20. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

\_\_\_\_\_ 1- Not as all          2-Slightly          3-Moderately          4-Quite a bit          5-Extremely \_\_\_\_\_

21. How much bodily pain have you had during the past 4 weeks?

\_\_\_\_\_ 1-None          2-Very Mild          3-Mild          4-Moderate          5-Severe          6-Very Severe \_\_\_\_\_



## Health Questionnaire – Page 2

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

22. During the past 4 weeks, how much did pain interfere with your normal work, in and out of the home?

1-Not at all                      2-A little bit                      3-Moderately                      4-Quite a bit                      5-Extremely

**These questions are about how you feel and how things have been with you during the past 4 weeks. For each questions, please give the one answer that comes closest to the way you have been feeling.**

		All of the time	Most of the time	A good bit of the time	Some of the time	Little of the time	None of the time
23.	Did you feel full of pep?	1	2	3	4	5	6
24.	Have you been a very nervous person?	1	2	3	4	5	6
25.	Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
26.	Have you felt calm and peaceful?	1	2	3	4	5	6
27.	Did you have a lot of energy?	1	2	3	4	5	6
28.	Have you felt downhearted and blue?	1	2	3	4	5	6
29.	Did you feel worn out?	1	2	3	4	5	6
30.	Have you been a happy person?	1	2	3	4	5	6
31.	Did you feel tired?	1	2	3	4	5	6

32. During the past 4 weeks, how much of the time has your physical health or emotional health problems interfered with your social activities?

1-All of the time                      2-Most of the time                      3-Some of the time                      4-A little of the time                      5-None

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

		Definitely true	Mostly true	Don't know	Mostly false	Definitely false
33.	I seem to get sick a little easier than other people.	1	2	3	4	5
34.	I am as healthy as anybody I know.	1	2	3	4	5
35.	I expect my health to get worse.	1	2	3	4	5
36.	My health is excellent.	1	2	3	4	5



## Neck Questionnaire

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

**Please read carefully:**

*This questionnaire has been designed to enable us to understand how your neck pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only **ONE CHOICE** that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the one box that most closely describes your problem right now.*

**SECTION 1 - Pain Intensity**

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

**SECTION 6 - Concentration**

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

**SECTION 2 - Personal Care (washing, dressing, etc.)**

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

**SECTION 7 - Work**

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

**SECTION 3 - Lifting**

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

**SECTION 8 - Driving**

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

**SECTION 4 - Reading**

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

**SECTION 9 - Sleeping**

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

**SECTION 5 - Headaches**

- A. I have no headaches at all.
- B. I have slight headaches, which come infrequently.
- C. I have moderate headaches, which come infrequently.
- D. I have moderate headaches, which come frequently.
- E. I have severe headaches, which come frequently.
- F. I cannot concentrate at all.

**SECTION 10 - Recreation**

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



## Low Back Questionnaire

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

**Please read carefully:**

*This questionnaire has been designed to enable us to understand how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only **ONE CHOICE** that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the one box that most closely describes your problem right now.*

<b>SECTION 1 - Pain Intensity</b>	<b>SECTION 6 - Standing</b>
A. The pain comes and goes and is very mild.	A. I can stand as long as I want without pain.
B. The pain is mild and does not vary much.	B. I have some pain while standing, but it does not increase with time.
C. The pain comes and goes and is moderate.	C. I cannot stand for longer than 1 hour without increasing pain.
D. The pain is moderate and does not vary much.	D. I cannot stand for longer than ½ hour without increasing pain.
E. The pain comes and goes and is very severe.	E. I cannot stand for longer than 10 minutes without increasing pain.
F. The pain is severe and does not vary much.	F. Pain prevents me from standing at all.
<b>SECTION 2 - Personal Care</b>	<b>SECTION 7 - Sleeping</b>
A. I would not have to change my way of washing or dressing in order to avoid pain.	A. I get no pain in bed.
B. I do not normally change my way of washing or dressing even though it causes some pain.	B. I get pain in bed, but it does not prevent me from sleeping well.
C. Washing and dressing increases the pain, but I manage not to change my way of doing it.	C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.	D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of the pain, I am unable to some washing and dressing without help.	E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Because of the pain, I am unable to do any washing or dressing without help.	F. Pain prevents me from sleeping at all.
<b>SECTION 3 - Lifting</b>	<b>SECTION 8 - Social Life</b>
A. I can lift heavy weights without extra pain.	A. My social life is normal and gives me no pain.
B. I can lift heavy weights but it gives extra pain.	B. My social life is normal, but increases the degree of my pain.
C. Pain prevents me from lifting heavy weights of the floor.	C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.	D. Pain has restricted my social life and I do not go out very often.
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.	E. Pain has restricted my social life to home.
F. I can only lift very light weights, at the most.	F. I have hardly any social life because of the pain.
<b>SECTION 4 - Walking</b>	<b>SECTION 9 - Traveling</b>
A. Pain does not prevent me from walking any distance.	A. I get no pain while traveling.
B. Pain prevents me from walking more than 1 mile.	B. I get some pain while traveling but none of my usual forms of travel make it any worse.
C. Pain prevents me from walking more than ½ mile.	C. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
D. Pain prevents me from walking more than ¼ mile.	D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. I can walk using a stick or crutches.	E. Pain restricts all forms of travel.
F. I am in bed most of the time and have to crawl to the toilet.	F. Pain prevents all forms of travel except that done lying down.
<b>SECTION 5 - Sitting</b>	<b>SECTION 10 - Changing Degree of Pain</b>
A. I can sit in any chair as long as I like without pain.	A. My pain is rapidly getting better.
B. I can only sit in my favorite chair as long as I like.	B. My pain fluctuates, but overall is definitely getting better.
C. Pain prevents me sitting more than 1 hour.	C. My pain seems to be getting better, but improvement is slow at present.
D. Pain prevents me sitting more than ½ hour.	D. My pain is neither getting better nor worse.
E. Pain prevents me sitting more than 10 minutes.	E. My pain is gradually worsening.
F. Pain prevents me from sitting at all.	F. My pain is rapidly worsening.



Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

Last Name:	First Name:	Date:
Date of Injury:	Other Passengers:	

- Motor Vehicle Collision       Work-Related       Non-Work Related

**1. Description of Accident/Injury/Onset**

Enter a full description of the accident, injury or onset in the space below.

**2. Crash Diagram**

**3. Police Intervention**

Did police show up at the scene?  Yes  No    Was an accident report filled out?  Yes  No

<b>4. Specifics of Auto Accident</b>		<b>5. Immediately Following the accident:</b>	
<input type="checkbox"/> Driver <input type="checkbox"/> Front Seat <input type="checkbox"/> Braced <input type="checkbox"/> Did Head Strike Object <input type="checkbox"/> Shock <input type="checkbox"/> Air Bag Deployed <input type="checkbox"/> Other Car Air Bag Deployed	<input type="checkbox"/> Passenger <input type="checkbox"/> Back Seat <input type="checkbox"/> Not Braced <input type="checkbox"/> Head Did Not Strike Object <input type="checkbox"/> Flash of Light Seen Upon Impact	<input type="checkbox"/> Ambulance/Paramedics Called to Scene <input type="checkbox"/> Treated at Scene <input type="checkbox"/> Transported to Hospital by Ambulance <input type="checkbox"/> Went to Hospital on His/Her Own <input type="checkbox"/> Diagnostics Performed at Hospital <input type="checkbox"/> Medication Prescribed <input type="checkbox"/> Treatment at Hospital <input type="checkbox"/> Follow-Up Recommended	
<b>6. Time Loss</b>			
<input type="checkbox"/> Patient reports no time loss due to injury and is currently working <b>with no</b> limitations <input type="checkbox"/> Patient reports no time loss due to injury and is currently working <b>with</b> limitations <input type="checkbox"/> Patient reports time loss due to injury (Amount of Days, Weeks, Etc.) _____ <input type="checkbox"/> N/A Additional Comments _____			
<b>7. Mechanism of Injury</b>			
Were you surprised by the impact?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
In relation to the back of your head, was your headrest set:		<input type="checkbox"/> Low	<input type="checkbox"/> Middle
		<input type="checkbox"/> High	<input type="checkbox"/> None
Where was your head facing at the time of impact?		<input type="checkbox"/> Left	<input type="checkbox"/> Forward
		<input type="checkbox"/> Right	<input type="checkbox"/> unknown
Were you leaning forward at the time of impact?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Were you wearing a seatbelt/harness?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Were you rendered unconscious as a result of the accident?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did you feel pain immediately after the accident?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Year and type of vehicle you were in?			
Size of your vehicle?		<input type="checkbox"/> SM	<input type="checkbox"/> MED
		<input type="checkbox"/> LG	
Year and type of other vehicle involved in accident?			
Size of other vehicle?		<input type="checkbox"/> SM	<input type="checkbox"/> MED
		<input type="checkbox"/> LG	<input type="checkbox"/> unknown
What was the approximate speed of your vehicle when the accident occurred?		MPH	
What was the approximate speed of the other vehicle when the accident occurred?		MPH	
<b>8. What was your vehicle doing at the time of the accident?</b>			
<input type="checkbox"/> Stopped at intersection <input type="checkbox"/> Making a right turn <input type="checkbox"/> Proceeding along		<input type="checkbox"/> Stopped in traffic <input type="checkbox"/> Making a left turn <input type="checkbox"/> Slowing down	
		<input type="checkbox"/> Stopped at a light <input type="checkbox"/> Parking <input type="checkbox"/> Accelerating	
<b>9. Time/Damage</b>		<b>10. Details of Accident</b>	
Time of accident? _____		<b>Visibility at time of accident</b>	
<b>Damage to your vehicle</b>		<input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good	
<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Totaled <b>Damage to other vehicle</b> <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Totaled		<b>Who hit who/what?</b>	
		<input type="checkbox"/> You hit other vehicle <input type="checkbox"/> You hit...(object) _____ <input type="checkbox"/> Other vehicle hit you	
<b>11. Road conditions</b>		<b>12. During the accident, were any items displaced in the vehicle?</b>	
<b>Road conditions at the time of accident</b>		Did your body strike the inside of your vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Icy <input type="checkbox"/> Wet <input type="checkbox"/> Sandy <input type="checkbox"/> Dark <input type="checkbox"/> Clean & dry <b>Road Type:</b> <input type="checkbox"/> Pavement <input type="checkbox"/> Concrete <input type="checkbox"/> Dirt <input type="checkbox"/> Gravel		What area struck? <input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Chest <input type="checkbox"/> Arm <input type="checkbox"/> Hand <input type="checkbox"/> Knee <input type="checkbox"/> Foot <b>If yes, describe</b> _____	

**13. Additional accident information**

In case of a motor vehicle accident, enter any additional information here that is not covered by the above questions. If additional space is needed, please feel free to write on the back of this form.

**14. After the accident:**
**Check off your symptoms right after and a few days following:**

- |   |                                       |  |  |
|---|---------------------------------------|--|--|
| <input type="checkbox"/> Headache         | <input type="checkbox"/> Dizziness    | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Cold hands        |
| <input type="checkbox"/> Neck pain        | <input type="checkbox"/> Nausea       | <input type="checkbox"/> Mid back pain       | <input type="checkbox"/> Cold feet         |
| <input type="checkbox"/> Neck stiffness   | <input type="checkbox"/> Confusion    | <input type="checkbox"/> Low back pain       | <input type="checkbox"/> Diarrhea          |
| <input type="checkbox"/> Fainting         | <input type="checkbox"/> Fatigue      | <input type="checkbox"/> Nervousness         | <input type="checkbox"/> Depression        |
| <input type="checkbox"/> Ringing in ears  | <input type="checkbox"/> Tension      | <input type="checkbox"/> Loss of taste       | <input type="checkbox"/> Anxious           |
| <input type="checkbox"/> Loss of smell    | <input type="checkbox"/> Irritability | <input type="checkbox"/> Toe numbness        | <input type="checkbox"/> Chest Pain        |
| <input type="checkbox"/> Pain behind eyes | <input type="checkbox"/> Shock        | <input type="checkbox"/> Constipation        | <input type="checkbox"/> Sleeping problems |

Others: \_\_\_\_\_

**15. Emergency Room?**
**Where did you go after the accident?**

- 
- Home
- 
- Work
- 
- Hospital ER
- 
- Private Doctor

**Were X-rays done?**  Yes  No      **Was lab work done?**  Yes  No

Body parts X-rayed? \_\_\_\_\_

What lab work? \_\_\_\_\_

The X-rays revealed: \_\_\_\_\_

**Treatments:**  Cervical Collar    Ice   **Other:** \_\_\_\_\_

Medications: \_\_\_\_\_

Follow-up instructions: \_\_\_\_\_

**16. Social History**

- |                                   |   |
|-----------------------------------|---|
| <input type="checkbox"/> Single   | <input type="checkbox"/> Smoker                 |
| <input type="checkbox"/> Married  | <input type="checkbox"/> Non-Smoker             |
| <input type="checkbox"/> Divorced | <input type="checkbox"/> Drinks Alcohol         |
| Number of Children: _____         | <input type="checkbox"/> Does not drink Alcohol |
|                                   | <input type="checkbox"/> Takes Drugs            |
|                                   | <input type="checkbox"/> Does not take Drugs    |

**List Hobbies & Exercise Activities:** \_\_\_\_\_

 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**17. Occupational History**

Your Employer \_\_\_\_\_

Job Title \_\_\_\_\_

What is your current job satisfaction:

- 
- Very Satisfied
- 
- 
- Satisfied
- 
- 
- Dissatisfied
- 
- 
- Very Dissatisfied

 Are your Job Duties Physically demanding for you?  YES  NO

 If you are currently working which are you performing?  Regular Duties    Light Duties    None

Highest level of education attained? \_\_\_\_\_

**18. Other care for this condition**

Chiropractor (Name): \_\_\_\_\_

Massage Therapist: \_\_\_\_\_

Neurologist: \_\_\_\_\_

Orthopedist: \_\_\_\_\_

Physical Therapist: \_\_\_\_\_

Physician: \_\_\_\_\_

Psychiatrist/Psychologist: \_\_\_\_\_

Other: \_\_\_\_\_

**Treatments I've had for this condition:**

- |   |                                      |
|---|--------------------------------------|
| <input type="checkbox"/> Ice                          | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Heat/Ultrasound              | <input type="checkbox"/> Naturopathy |
| <input type="checkbox"/> Electrical Stimulation       | <input type="checkbox"/> Massage     |
| <input type="checkbox"/> Exercises                    |                                      |
| <input type="checkbox"/> Gravity Inversion – Traction |                                      |
| <input type="checkbox"/> Bed Rest                     |                                      |
| <input type="checkbox"/> Chiropractic                 |                                      |
| <input type="checkbox"/> Osteopathy                   |                                      |
| <input type="checkbox"/> Injections                   |                                      |

<b>Diagnostic Testing that I've had for this condition:</b>	
<input type="checkbox"/> X-rays <input type="checkbox"/> CT Scan <input type="checkbox"/> Myelogram <input type="checkbox"/> MRI	<input type="checkbox"/> Discogram <input type="checkbox"/> Bone Scan <input type="checkbox"/> EMG
<b>19. List previous back, neck &amp; musculoskeletal problems:</b>	<b>20. Females – Mark if have the following:</b>
	<input type="checkbox"/> Vaginal bleeding other than period <input type="checkbox"/> Pap smear within last two years <input type="checkbox"/> Painful menstrual periods <input type="checkbox"/> Back pain with menstrual periods <input type="checkbox"/> Other menstrual problems
<b>21. Mark if you have had any of the following symptoms in the past 5 years:</b>	
<input type="checkbox"/> Unexplained fevers <input type="checkbox"/> Night sweats <input type="checkbox"/> Weight loss of 10 lbs or more <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Excessive fatigue <input type="checkbox"/> Problems with depression <input type="checkbox"/> Difficulty sleeping <input type="checkbox"/> Unusual stress at work <input type="checkbox"/> Unusual stress at home <input type="checkbox"/> Easy bruising <input type="checkbox"/> Excessive bleeding <input type="checkbox"/> Lumps in neck, armpit or groin <input type="checkbox"/> Chest pain or tightness <input type="checkbox"/> Persistent or unusual cough <input type="checkbox"/> Trouble breathing with exercise <input type="checkbox"/> Trouble breathing lying flat <input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Swollen ankles <input type="checkbox"/> Stomach pain <input type="checkbox"/> Change in bowel habits <input type="checkbox"/> Persistent diarrhea <input type="checkbox"/> Excessive constipation <input type="checkbox"/> Dark black stools <input type="checkbox"/> Blood in stools <input type="checkbox"/> Pain-burning when urinating <input type="checkbox"/> Difficulty urinating – start / stop <input type="checkbox"/> Blood in urine <input type="checkbox"/> Need to urinate more at night <input type="checkbox"/> Morning stiffness <input type="checkbox"/> Persistent eye redness <input type="checkbox"/> Muscle tenderness <input type="checkbox"/> Dry eyes or mouth <input type="checkbox"/> Skin rashes <input type="checkbox"/> Joint pain or swelling
<b>22. Activities which you have performed despite pain, due to financial, family or personal needs (Duties Under Duress):</b>	
<input type="checkbox"/> Work <input type="checkbox"/> Education <input type="checkbox"/> Domestic (Activities within the Home) <input type="checkbox"/> Household (Duties outside the Home)	