

# Patient Basic Information

## Personal Information:

Last Name:		First Name:		Mid. Init.:
Address:		City, State, Zip:		
Home Phone:	Work Phone:		Social Security No.:	
Date of Birth:		Date of Injury/Onset:		
Dominant Hand:		<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
Insurance Information: Policy Holder (if different than patient):			Policy No.:	

**Special Note: If your injury involved a motor vehicle, skip to page 2. Otherwise, use the spaces below to fully describe your accident, injury or onset, slip and fall, etc.**

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

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

### 2. Your condition during and immediately after injury/onset

Enter the details of your condition during and immediately after your injury/onset.

## Automobile Accident Description

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

### 1. Your vehicle type

Car     Station Wagon  
 Van     Pickup Truck  
 Large Truck     Bus  
 Other \_\_\_\_\_

### 2. Your position in vehicle

Driver     Front Passenger  
 Left Rear Passenger  
 Right Rear Passenger  
 Other \_\_\_\_\_

### 3. What was your vehicle doing at the time of the accident?

Stopped at intersection     Stopped in traffic     Stopped at light  
 Making a right turn     Making a left turn     Parking  
 Proceeding along     Slowing down     Accelerating  
 Other \_\_\_\_\_

### 4. Time/Speed/Damage

Time of accident \_\_\_\_\_  
 Your vehicle's speed: \_\_\_\_\_ mph  
 Their vehicle's speed: \_\_\_\_\_ mph  
**Damage to your vehicle**  
 Mild     Moderate  
 Totaled

### 5. Details of Accident

**Visibility at time of accident**  
 Poor     Fair     Good  
**Who hit who/what?**  
 You hit other vehicle  
 Other vehicle hit you  
**You hit...(object)**  
 \_\_\_\_\_

### 6. Road conditions

**Road conditions at time of accident**  
 Icy     Wet     Sandy     Dark     Clean and dry  
**Point of impact**  
 Head-On     Left Front     Right Front  
 Read-End     Left Rear     Right Rear

### 7. Body Position, etc.

Did you see the accident coming?    Yes   No  
 Were you braced for the impact?    Yes   No  
 Did you have a seat belt on?    Yes   No  
 Did you have a shoulder harness on?    Yes   No

**Does your vehicle have headrests? Yes   No**  
**What was the position of your headrest at the time of the impact?**  
 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 impact?**  
 Facing straight forward     Turned to the right     Turned to the left

Did driver side air bags deploy? Yes   No    Did passenger side airbags deploy? Yes   No    Did side airbags deploy? Yes   No

### 8. Additional accident information

In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

### 9. During the accident:

Did your body strike the inside of your vehicle?    Yes   No  
 If yes, describe: \_\_\_\_\_  
 Did you lose consciousness during the injury?    Yes   No  
 If yes, for how long? \_\_\_\_\_  
 Your vehicle's estimated damage? \_\_\_\_\_  
**Damage to their vehicle:**     Mild     Moderate     Totaled  
 Did police show up at the scene?    Yes   No  
 Was an accident report filled out?    Yes   No

### 10. After the accident:

**Check off your symptoms right after and a few days following:**  
 Headache     Dizziness     Mid back pain     Cold hands  
 Neck pain     Nausea     Low back pain     Cold feet  
 Neck stiffness     Confusion     Nervousness     Diarrhea  
 Fainting     Fatigue     Loss of taste     Depression  
 Ringing in ears     Tension     Toe numbness     Anxious  
 Loss of smell     Irritability     Constipation     Chest Pain  
 Pain behind eyes     Shortness of breath     Sleeping problems  
 Others: \_\_\_\_\_

### 11. Emergency Room?

**Where did you go after the accident?**  
 Home     Work     Hospital ER     Private Doctor  
**How did you get there?**  
 Drove self     Somebody else     Ambulance     Police  
**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: \_\_\_\_\_

### 12. Treatment History:

**Fill in any other doctor(s) seen prior to your first visit to this office.**  
**1. Dr.** \_\_\_\_\_ First visit date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Specialty: \_\_\_\_\_ X-rays done?    Yes   No  
 Types of treatments received: \_\_\_\_\_  
 How many treatments received? \_\_\_\_ Currently treating? Yes   No  
 Did treatments benefit you? Yes   No  
 Last visit date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
**2. Dr.** \_\_\_\_\_ First visit date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Types of treatments received: \_\_\_\_\_  
 How many treatments received? \_\_\_\_ Currently treating: Yes   No  
 Did treatments benefit you? Yes   No  
 Last visit date: \_\_\_\_/\_\_\_\_/\_\_\_\_

# Description of Symptoms (Describe your symptoms in the sections below, in the order of severity, if possible.)

## I. First Current Symptom: (Please check off the boxes below to describe your first symptom. Describe only ONE symptom per Section)

<p><b>1. Check only one body location below</b></p> <p><input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Front of Head</p> <p><input type="checkbox"/> Top of Head</p> <p><input type="checkbox"/> Back of Head</p> <p><input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p>Other locations: _____</p>	<p><b>2. 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<p><b>3. Pain Frequency</b></p> <p><input type="checkbox"/> Up to 1/4 of awake time <input type="checkbox"/> 1/4 to 1/2 of time</p> <p><input type="checkbox"/> 1/2 to 3/4 of awake time <input type="checkbox"/> Most all the time</p>	<p><b>4. Pain Intensity (How it affects your daily activities)</b></p> <p><input type="checkbox"/> Doesn't affect <input type="checkbox"/> Somewhat affects</p> <p><input type="checkbox"/> Seriously affects <input type="checkbox"/> Prevents activities</p>																																																																	
<p><b>5. Does this pain radiate into other body parts?</b></p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Left</th> <th>Right</th> <th>Both</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> Head</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Neck</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Shoulder</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Arm</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Hand</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Hip</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Leg</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Foot</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table> <p>Other locations of radiation: _____</p>				Left	Right	Both	<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																												
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## II. Second Current Symptom: (Please check off the boxes below to describe your next symptom).

<p><b>1. Check only one body location below</b></p> <p><input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Front of Head</p> <p><input type="checkbox"/> Top of Head</p> <p><input type="checkbox"/> Back of Head</p> <p><input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p>Other locations: _____</p>	<p><b>2. 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<p><b>3. Pain Frequency</b></p> <p><input type="checkbox"/> Up to 1/4 of awake time <input type="checkbox"/> 1/4 to 1/2 of time</p> <p><input type="checkbox"/> 1/2 to 3/4 of awake time <input type="checkbox"/> Most all the time</p>	<p><b>4. Pain Intensity (How it affects your daily activities)</b></p> <p><input type="checkbox"/> Doesn't affect <input type="checkbox"/> Somewhat affects</p> <p><input type="checkbox"/> Seriously affects <input type="checkbox"/> Prevents activities</p>																																																																	
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## III. Third Current Symptom: (Please check off the boxes below to describe your 3rd symptom).

<p><b>1. Check only one body location below</b></p> <p><input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Front of Head</p> <p><input type="checkbox"/> Top of Head</p> <p><input type="checkbox"/> Back of Head</p> <p><input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p>Other locations: _____</p>	<p><b>2. Types of pain</b></p> <p><input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Aching <input type="checkbox"/> Cutting</p> <p><input type="checkbox"/> Throbbing <input type="checkbox"/> Burning <input type="checkbox"/> Numbing <input type="checkbox"/> Tingling <input type="checkbox"/> Cramping</p> <p><input type="checkbox"/> Spasm <input type="checkbox"/> Stinging <input type="checkbox"/> Shooting <input type="checkbox"/> Pounding <input type="checkbox"/> Constricting</p> <p>Other types of pain: _____</p>	<p><b>6. 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# Description of Symptoms

(Describe your symptoms in the sections below, in the order of severity, if possible.)

<b>IV. Fourth Symptom:</b> (Please check off the boxes below to describe your 4th symptom. Describe only ONE symptom per Section.)																																																															
<b>1. Check only one body location below</b> <input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Front of Head <input type="checkbox"/> Top of Head <input type="checkbox"/> Back of Head  <input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Other locations: _____	<b>2. Types of pain</b> <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Aching <input type="checkbox"/> Cutting <input type="checkbox"/> Throbbing <input type="checkbox"/> Burning <input type="checkbox"/> Numbing <input type="checkbox"/> Tingling <input type="checkbox"/> Cramping <input type="checkbox"/> Spasm <input type="checkbox"/> Stinging <input type="checkbox"/> Shooting <input type="checkbox"/> Pounding <input type="checkbox"/> Constricting Other types of pain: _____	<b>3. Pain Frequency</b> <input type="checkbox"/> Up to 1/4 of awake time <input type="checkbox"/> 1/4 to 1/2 of time <input type="checkbox"/> 1/2 to 3/4 of awake time <input type="checkbox"/> Most all the time																																																													
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<b>V. Fifth Current Symptom:</b> (Please check off the boxes below to describe your 5th symptom).																																																															
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<b>4. Pain Intensity</b> (How it affects your daily activities) <input type="checkbox"/> Doesn't affect <input type="checkbox"/> Somewhat affects <input type="checkbox"/> Seriously affects <input type="checkbox"/> Prevents activities	<b>5. Does this pain radiate into other body parts?</b> <table style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">Left</td> <td style="text-align: center;">Right</td> <td style="text-align: center;">Both</td> </tr> <tr> <td><input type="checkbox"/> Head</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Neck</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Arm</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Hand</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Hip</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Leg</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Foot</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> Other locations of radiation: _____				Left	Right	Both	<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
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<b>VI. Sixth Current Symptom:</b> (Please check off the boxes below to describe your 6th symptom).																																																															
<b>1. Check only one body location below</b> <input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Front of Head <input type="checkbox"/> Top of Head <input type="checkbox"/> Back of Head  <input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Other locations: _____	<b>2. Types of pain</b> <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Aching <input type="checkbox"/> Cutting <input type="checkbox"/> Throbbing <input type="checkbox"/> Burning <input type="checkbox"/> Numbing <input type="checkbox"/> Tingling <input type="checkbox"/> Cramping <input type="checkbox"/> Spasm <input type="checkbox"/> Stinging <input type="checkbox"/> Shooting <input type="checkbox"/> Pounding <input type="checkbox"/> Constricting Other types of pain: _____	<b>3. Pain Frequency</b> <input type="checkbox"/> Up to 1/4 of awake time <input type="checkbox"/> 1/4 to 1/2 of time <input type="checkbox"/> 1/2 to 3/4 of awake time <input type="checkbox"/> Most all the time																																																													
<b>4. Pain Intensity</b> (How it affects your daily activities) <input type="checkbox"/> Doesn't affect <input type="checkbox"/> Somewhat affects <input type="checkbox"/> Seriously affects <input type="checkbox"/> Prevents activities	<b>5. Does this pain radiate into other body parts?</b> <table style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">Left</td> <td style="text-align: center;">Right</td> <td style="text-align: center;">Both</td> </tr> <tr> <td><input type="checkbox"/> Head</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Neck</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Arm</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Hand</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Hip</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Leg</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Foot</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> Other locations of radiation: _____				Left	Right	Both	<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
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<b>6. Actions affecting this pain</b> <table style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">Brings On</td> <td style="text-align: center;">Aggravates</td> <td style="text-align: center;">Relieves</td> </tr> <tr> <td><input type="checkbox"/> In the A.M.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> In the P.M.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Bending forward</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input 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<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																												

# Description of Symptoms

(Describe your symptoms in the sections below, in the order of severity, if possible.)

<b>VII. Seventh Symptom:</b> (Please check off the boxes below to describe your 7th symptom. Describe only ONE symptom per Section.)																																																															
<b>1. Check only one body location below</b> <input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Front of Head <input type="checkbox"/> Top of Head <input type="checkbox"/> Back of Head  <input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Other locations : _____	<b>2. Types of pain</b> <span style="float:right">Other types of pain: _____</span> <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Aching <input type="checkbox"/> Cutting <input type="checkbox"/> Throbbing <input type="checkbox"/> Burning <input type="checkbox"/> Numbing <input type="checkbox"/> Tingling <input type="checkbox"/> Cramping <input type="checkbox"/> Spasm <input type="checkbox"/> Stinging <input type="checkbox"/> Shooting <input type="checkbox"/> Pounding <input type="checkbox"/> Constricting	<b>3. Pain Frequency</b> <input type="checkbox"/> Up to 1/4 of awake time <input type="checkbox"/> 1/4 to 1/2 of time <input type="checkbox"/> 1/2 to 3/4 of awake time <input type="checkbox"/> Most all the time																																																													
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<b>IX. Ninth Current Symptom:</b> (Please check off the boxes below to describe your 9th symptom).																																																															
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## Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty: **1** = "I can do it without any difficulty", **2** = "I can do it without much difficulty, despite some pain", **3** = "I manage to do it by myself, despite marked pain", **4** = "I manage to do it, despite the pain, but only if I have help", **5** = "I cannot do it at all, because of the pain". **NOTE: Only fill in areas that are affected.**

### Difficulties with Self Care and Personal Hygiene Activities

Bathing ..... \_\_\_ Drying hair ..... \_\_\_ Brushing teeth ..... \_\_\_ Putting on shoes ..... \_\_\_ Preparing meals ..... \_\_\_ Taking out trash .. \_\_\_  
 Showering ..... \_\_\_ Combing hair ..... \_\_\_ Making bed ..... \_\_\_ Tying shoes ..... \_\_\_ Eating ..... \_\_\_ Doing laundry ..... \_\_\_  
 Washing hair .. \_\_\_ Washing face ..... \_\_\_ Putting on shirt .... \_\_\_ Putting on pants ..... \_\_\_ Cleaning dishes ..... \_\_\_ Going to toilet ..... \_\_\_

### Difficulties with Physical Activities

Standing ..... \_\_\_ Walking ..... \_\_\_ Kneeling ..... \_\_\_ Bending back ..... \_\_\_ Twisting left ..... \_\_\_ Leaning back ..... \_\_\_  
 Sitting ..... \_\_\_ Stooping ..... \_\_\_ Reaching ..... \_\_\_ Bending left ..... \_\_\_ Twisting right ..... \_\_\_ Leaning left ..... \_\_\_  
 Reclining ..... \_\_\_ Squatting ..... \_\_\_ Bending forward .. \_\_\_ Bending right ..... \_\_\_ Leaning forward ..... \_\_\_ Leaning right ..... \_\_\_  
 Standing for long periods ..... \_\_\_ Sitting for long periods..... \_\_\_ Walking for long periods..... \_\_\_ Kneeling for long periods ..... \_\_\_

### Difficulties with Functional Activities

Carrying small objects ..... \_\_\_ Lifting weights off floor ..... \_\_\_ Pushing things while seated .... \_\_\_ Exercising upper body ..... \_\_\_  
 Carrying large objects ..... \_\_\_ Lifting weights off table ..... \_\_\_ Pushing things while standing .. \_\_\_ Exercising lower body ..... \_\_\_  
 Carrying brief case ..... \_\_\_ Climbing stairs ..... \_\_\_ Pulling things while seated ..... \_\_\_ Exercising arms ..... \_\_\_  
 Carrying large purse ..... \_\_\_ Climbing inclines ..... \_\_\_ Pulling things while standing .... \_\_\_ Exercising legs ..... \_\_\_

### Difficulties with Social and Recreational Activities

Bowling ..... \_\_\_ Jogging ..... \_\_\_ Swimming ..... \_\_\_ Ice Skating ..... \_\_\_ Competitive Sports . \_\_\_ Dating ..... \_\_\_  
 Golfing ..... \_\_\_ Dancing ..... \_\_\_ Skiing ..... \_\_\_ Roller Skating ..... \_\_\_ Hobbies ..... \_\_\_ Dining out ..... \_\_\_

### Difficulties with Travelling

Driving a motor vehicle ..... \_\_\_ Riding as a passenger in a motor vehicle ..... \_\_\_ Riding as a passenger on a train ..... \_\_\_  
 Driving for long periods of time ..... \_\_\_ Riding as a passenger on an airplane ..... \_\_\_ Riding as a passenger for long periods ..... \_\_\_

Use the following **1 to 5** scale to describe the difficulties below:

**1** = "This area is not affected by my condition", **2** = "This area is slightly affected by my condition", **3** = "My condition moderately restricts my ability in this area", **4** = " My condition seriously limits my ability in this area", **5** = "My condition prevents me from using this ability"

### Difficulties with Different Forms of Communication

Concentrating.... \_\_\_ Hearing.... \_\_\_ Listening.... \_\_\_ Speaking.... \_\_\_ Reading.... \_\_\_ Writing.... \_\_\_ Using a keyboard.... \_\_\_

### Difficulties with the Senses

Seeing..... \_\_\_ Hearing..... \_\_\_ Sense of touch..... \_\_\_ Sense of taste..... \_\_\_ Sense of smell..... \_\_\_

### Difficulties with Hand Functions

Grasping..... \_\_\_ Holding..... \_\_\_ Pinching..... \_\_\_ Percussive movements..... \_\_\_ Sensory discrimination..... \_\_\_

### Difficulties with Sleep and Sexual Function

Being able to have normal, restful nights sleep..... \_\_\_ Being able to participate in desired sexual activity..... \_\_\_

**Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):**

### 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.

#### Has your History Contributed to your Current Symptoms?

- My history HAS contributed to my current symptoms.  
 My history HAS NOT contributed to my current symptoms.  
 I'm NOT SURE if my history has contributed to my current symptoms.

My most recent prior similar symptoms (if applicable) occurred..... \_\_\_  months ago /  years ago **Or on** Date: \_\_\_/\_\_\_/\_\_\_

**Write in below any other Prior Symptom History, not covered above:**