

The symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas. Just to complete the picture, please draw in your face.

Aching
▲ ▲ ▲

Numbness
= = =

Pins and needles
○ ○ ○

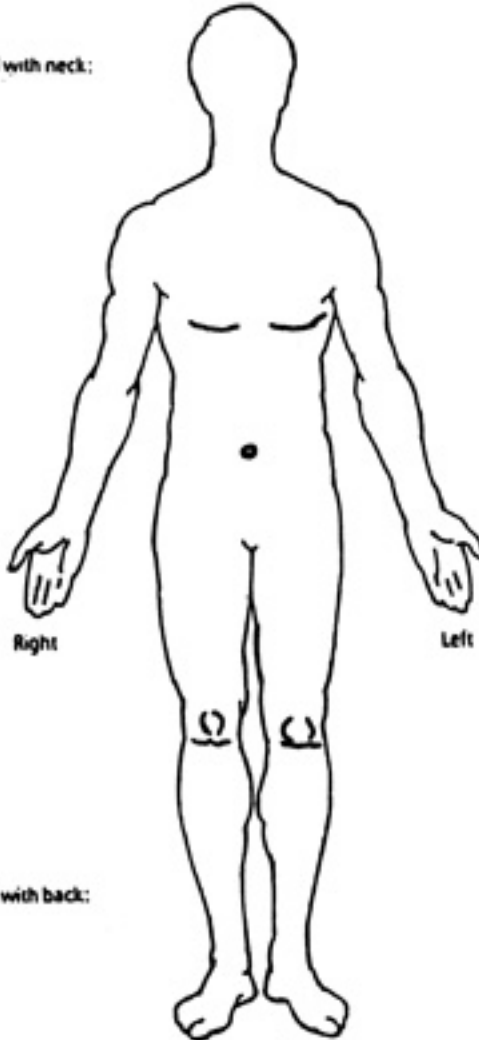
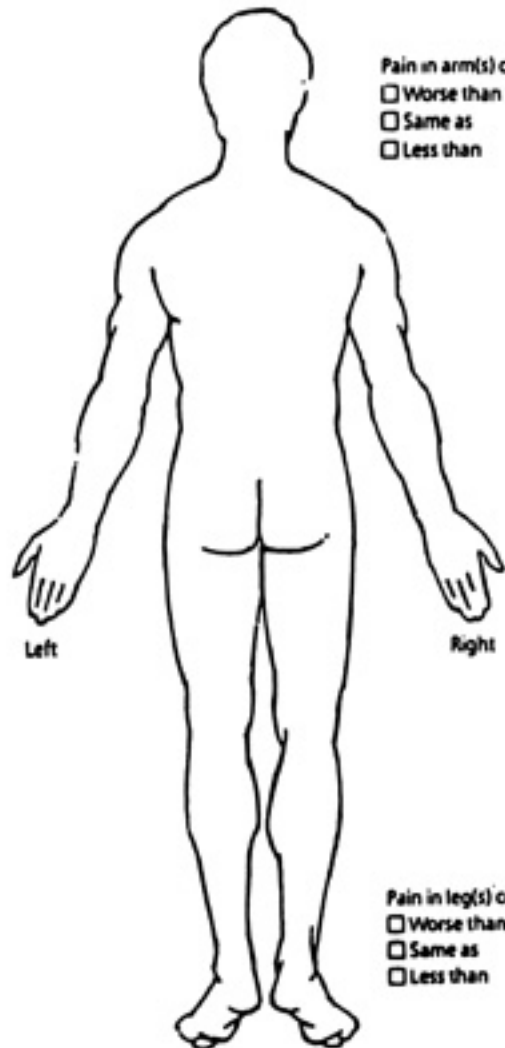
Burning
x x x

Stabbing
/ / /

Other
● ● ●

Back

Front



Pain in arm(s) compared with neck:

- Worse than
- Same as
- Less than

Pain in leg(s) compared with back:

- Worse than
- Same as
- Less than

****Is the problem we are seeing you for today a WORK related accident/injury?
YES / NO**

Personal Injury

The following questions are designed to provide your physician with a thorough understanding of your injury and medical history. Please answer every question as completely as you can.

1. Name _____ Age _____ Height _____ Weight _____
2. Please describe the following about THIS accident or injury:
 - A. Date of the accident or injury?
 - B. If AUTO ACCIDENT, were you the: driver/front passenger/rear passenger?
Were you wearing a seatbelt? Yes/No
Did you lose consciousness? Yes/No
Please describe your accident:
 - C. If your injury did not occur as a result of an auto accident, please describe:
 - D. Did you go to an Emergency Room following your accident?
Yes/No If so, by ambulance? Yes/No
Which Hospital?
Were xrays taken? Yes/No
 - E. Have you seen any additional physicians or chiropractors for this injury? Yes/No If so, please list names, dates seen, and any treatment given:
3. Please mark the following scale to show the type of pain that you are having: (use the following as a rough guide)

0= no pain
3= take Tylenol or Advil for pain
6= see your doctor for prescription pain medications
10=worst pain you could ever have (suicidal pain)

0-----2-----3-----4-----5-----6-----7-----8-----9-----10
4. What position or activity makes your injury or pain worse?
5. What position or activity reduces your pain?

6. Has this injury affected your sleep? Yes/No
7. Have you ever had a neck or back injury or neck or back pain prior to this injury or accident? Yes/No If so, please describe:
8. Have you ever been given a permanent disability rating as a result of this injury or a previous injury? Yes/No
If yes, please describe:
9. Have you ever had any of the following tests or treatments performed (if so, please give date and location that test or treatment took place and results, if known).
 - A) Myelogram
 - B) CAT Scan
 - C) MRI Scan
 - D) Bone Scan
 - E) EMG or Nerve Conduction Studies
 - F) Physical Therapy
 - G) TENS Unit
 - H) Back Brace
 - I) Trigger Point Injection
 - J) Epidural Steroid Injection
 - K) Facet Joint Injection
 - L) Discogram
 - M) Neck or Back Surgery
10.
 - A) List any drug allergies or sensitivities you have:
 - B) List all prescription medications you are currently taking (also include the dose or amount, and how many times a day you take it).
 - C) List any additional medical problems or surgeries you have had:
11.
 - A) Have you ever been diagnosed with Hepatitis? Yes/No
 - B) Have you ever been diagnosed with AIDS or HIV Positive? Yes/No
 - C) Have you ever been diagnosed with Arthritis? Yes/No
 - D) Have you ever been diagnosed with Diabetes? Yes/No
 - E) Have you ever been diagnosed or been treated for Ulcers? Yes/No
 - F) Have you ever had any unplanned weight loss? Yes/No
 - G) Have you ever had any problem with night sweats or fever? Yes/No
 - H) Have you had any weakness or numbness in leg or arm? Yes/No
If yes, please explain activities related to this.
 - I) Have you had any changes in Bowel/Bladder Functioning? Yes/No
If yes, explain.

12. A) Are you: Married/Single/Divorced/Widow/Widower?
B) If you have children please list their ages:
C) Do you smoke? Yes/No If yes, how many cigarettes per day? How many years have you smoked?
D) Please describe your education (grade school, HS degree, GED, trade school, college, post graduate):
E) What is your current job or occupation?
F) How long have you been working at this position?
G) Have you missed any work as a result of this injury? Yes/No If so, please list dates.

13. Family History -

What diseases, if any, does your mother have? (ex. heart disease, diabetes, arthritis, scoliosis, cancer)

What disease, if any, does your father have? (ex. heart disease, diabetes, arthritis, scoliosis, cancer)