



PERSONAL INJURY PATIENT INFORMATION

Name (First) (Middle) (Last) (Maiden)
Address City State Zip
Age Birthday Sex Status: M S W D # Children SSN
Home Phone Cellular/Pager Email
Occupation Employer Work Phone
Spouses/Guarantors Name Birthday SSN
Occupation Employer Work Phone
How did you here about our office?

If you were referred by a patient/Doctor or Attorney who may we thank?

PERSONAL HEALTH INSURANCE INFORMATION: (Please present insurance card(s) and a valid Identification card to the receptionist)

(Primary) Name of policy holder Relationship
(Secondary) Name of policy holder Relationship

YOUR CAR INSURANCE INFORMATION:

Your Ins. Co. Policy # Agents Name Phone #
Policy Holders Name Claim # Do you have Med-Pay? Yes No

RESPONSIBLE PARTYS CAR INSURANCE INFORMATION:

Responsible Party's Name Insurance Co. Phone #
Agents Name Phone #
Policy Holders Name Policy # Claim #

Name and telephone number of nearest relative/friend not living with you

What is your major complaint?

When did this condition begin? Have you had this or similar conditions in the past? Yes No

Is this condition getting progressively worse? Yes No Constant Comes and goes

Name other doctors seen for this condition

Family physician Address City

Tests done: X-ray's Urinalysis Blood tests MRI Other

Diagnosis Treatment

Length of time under care Medication for this condition Results

Is Condition: Job-Related Auto Accident Home Injury Fall Other

Date of Accident Time Place

Were you off work? If so for how long Have you returned to your same job? If not, why

Have you had any other personal injury or accident: Past year Past 5 years Over 5 years None

List previous accidents / injuries / major illnesses you have or have had

List surgical operations that you have had in the past 5 years.

Patient Name: _____

List any medications and non prescription drugs currently taking _____

Present illness /Conditions:					
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/>
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Ulcer	<input type="checkbox"/>
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Polio	<input type="checkbox"/>
<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> STD'S	<input type="checkbox"/>
<input type="checkbox"/> I currently have none of the above conditions. Other: _____					

Family History of illness:					
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease	<input type="checkbox"/> STD'S	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Polio
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diverticulitis
<input type="checkbox"/> I am unaware of my families medical history. Other: _____					

Type of Cancer: Breast Lung Other:
Who had the caner and what type? _____

Social History:	
Do you consume Alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	How many drinks per week?
Do you smoke cigarettes? <input type="checkbox"/> Yes <input type="checkbox"/> No	How many packs a day?
Do you consume caffeine (tea, Coffee, Soda) <input type="checkbox"/> Yes <input type="checkbox"/> No	How many glasses a day?
Do you exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Activity level <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Strenuous	How many hours a week?

Surgical History:	
Do you have a Pacemaker/defibulator? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, when was it implanted? _____
Have you ever had spinal surgery of any kind? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, where? _____	When was the surgery completed? _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

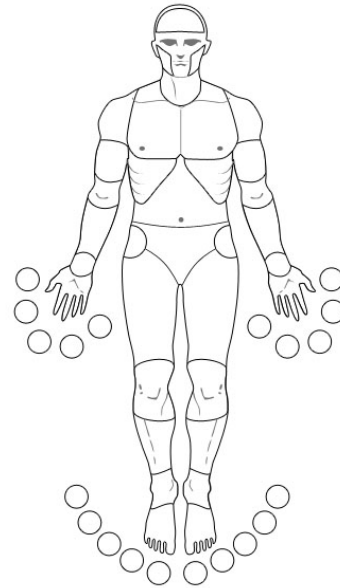
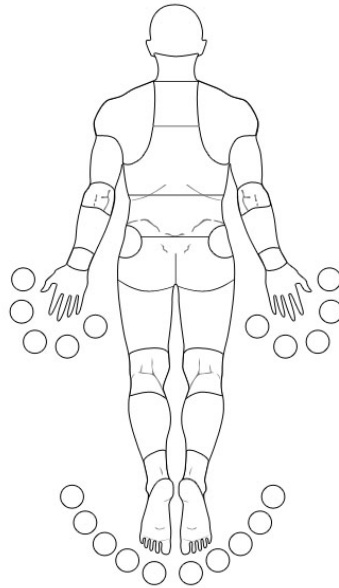
HISTORY OF SYMPTOMS

Patient's Name: _____

Date: _____

Please indicate the current complaints you are experiencing by marking the image below and providing details using the sections below.

1. Neck
2. Upper back
3. Mid Back
4. Lower Back
5. headaches
6. Hip
7. Buttock
8. Shoulder
9. Arm
10. Elbow
11. Forearm
12. Wrist
13. Hand
14. Fingers
15. Leg
16. Knee
17. Calf
18. Shin
19. Ankle
20. Foot
21. Toes
22. Chest
23. Ribs
24. Abdomen
25. Pelvis/Groin



NECK (Area 1)	Base of skull to base of neck
Location	<input type="checkbox"/> Right Front <input type="checkbox"/> Left Front <input type="checkbox"/> Right Back <input type="checkbox"/> Left Back <input type="checkbox"/> Center
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Increased sensitivity <input type="checkbox"/> Stiffness <input type="checkbox"/> Tightness <input type="checkbox"/> ROM
Radiates to	<input type="checkbox"/> Head <input type="checkbox"/> Forehead <input type="checkbox"/> Back of head <input type="checkbox"/> Right side of head <input type="checkbox"/> Left side of head <input type="checkbox"/> Both sides of head <input type="checkbox"/> Right shoulder blade <input type="checkbox"/> Left shoulder blade <input type="checkbox"/> Right shoulder <input type="checkbox"/> Left shoulder <input type="checkbox"/> Right arm <input type="checkbox"/> Left arm <input type="checkbox"/> Right forearm <input type="checkbox"/> Left forearm <input type="checkbox"/> Right hand <input type="checkbox"/> Left hand <input type="checkbox"/> Right fingers <input type="checkbox"/> Left fingers
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night <input type="checkbox"/> Light Activities <input type="checkbox"/> Moderate Activities
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Neck Movement <input type="checkbox"/> Sneezing <input type="checkbox"/> Prolonged Sitting <input type="checkbox"/> Prolonged Standing <input type="checkbox"/> Walking

UPPER BACK (Area 2)	Base of neck to between shoulder blades
Location	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Increased sensitivity <input type="checkbox"/> Tightness <input type="checkbox"/> Stiffness <input type="checkbox"/> ROM
Radiates to	<input type="checkbox"/> Neck <input type="checkbox"/> Right Ribs <input type="checkbox"/> Left Ribs <input type="checkbox"/> Lower back
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Upper body movement <input type="checkbox"/> Lifting <input type="checkbox"/> Working <input type="checkbox"/> Sneezing <input type="checkbox"/> Housework <input type="checkbox"/> Coughing <input type="checkbox"/> Bending Prolonged: <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking

HISTORY OF SYMPTOMS CONT.

MID BACK (Area 3)	<i>Between shoulder blades to bottom of ribs</i>
Location	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Increased sensitivity <input type="checkbox"/> Tightness <input type="checkbox"/> Stiffness <input type="checkbox"/> Decreased ROM
Radiates to	<input type="checkbox"/> Neck <input type="checkbox"/> Right Ribs <input type="checkbox"/> Left Ribs <input type="checkbox"/> Lower back
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> During Night <input type="checkbox"/> Light Activities <input type="checkbox"/> Moderate Activity
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Upper body movement <input type="checkbox"/> Lifting <input type="checkbox"/> Working <input type="checkbox"/> Sneezing <input type="checkbox"/> Housework <input type="checkbox"/> Coughing <input type="checkbox"/> Bending Prolonged: <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking
Other (Indicate #) _____	<i>List Body Part</i> _____
Location	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Increased sensitivity <input type="checkbox"/> Tightness <input type="checkbox"/> Stiffness <input type="checkbox"/> ROM
Pain Radiates to	Please Describe:
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
Pain Increased by better?	<input type="checkbox"/> Range of motion <input type="checkbox"/> Lifting <input type="checkbox"/> Bending <input type="checkbox"/> Laying down <input type="checkbox"/> Working <input type="checkbox"/> Housework <input type="checkbox"/> Coughing. <input type="checkbox"/> Sneezing Prolonged: <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Range of motion <input type="checkbox"/> Lifting <input type="checkbox"/> Bending <input type="checkbox"/> Lying down <input type="checkbox"/> Working <input type="checkbox"/> Housework <input type="checkbox"/> Coughing. <input type="checkbox"/> Sneezing Prolonged: <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If this doctor/therapist is a contracted provider for my managed care plan, I understand I am responsible for all co-payments, deductibles and any non-covered services. I also understand and agree to pay all co pays, deductibles and fees for non-covered services as agreed upon per the financial agreement with Eaton Chiropractic Inc. I understand that if I terminate my care and treatment, any balance for co-payments or deductibles will be immediately due and payable. If advanced payment is made and patient terminates care prior to completing the treatment schedule, no refunds will be made if there is any account balance.

I (we) authorize the doctor/therapist and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to prove any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of an consequences thereof. I agree that a photo static copy of this agreement shall serve as the original.

I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor/therapist as payment toward the total charges for professional services rendered. I (we) authorize the direct payment from my attorney, my car insurance company, or any other payer of my services. This payment will not exceed my indebtedness to the assignee. I agree that a photo copy of this agreement shall serve as the original.

Patient/Guardian Signature _____ Date _____

Doctors Signature _____ Date _____

Detailed Motor Vehicle Accident Information

Last Name:	First Name:
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General Information

Date of Accident:			
Location (circle one)	Driver		
	Passenger	Location (circle one)	Front / Middle / Rear
		Position (circle one)	Left / Middle / Right

Work from Left to Right and Circle One

Patients Vehicle	Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
	Action :	Stopped / Slowing / Acceleration / Cruising
	Speed : (MPH)	
	Time of Accident:	Day Light / Dawn / Dusk / Dark
	Road Condition :	Dry / Damp / Wet / Snow / Ice
	Visibility :	Good / Fair / Poor

Enter impact Information for up to three Vehicles or Objects

Impact Information: Vehicle or Object (I) (OTHER PARTY)

<input type="checkbox"/> (Select one)	Name Object :	
<input type="checkbox"/> Vehicle	Vehicle Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
<input type="checkbox"/> Object	Damage to Veh.:	Minimal / Moderate / Extensive / Totaled / Unsure
Impact Location		

Impact Information: Vehicle or Object (II) (OTHER PARTY)

<input type="checkbox"/> (Select one)	Name Object :	
<input type="checkbox"/> Vehicle	Vehicle Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
<input type="checkbox"/> Object	Damage to Veh.:	Minimal / Moderate / Extensive / Totaled / Unsure
Impact Location		

Impact Information: Vehicle or Object (III) (OTHER PARTY)

<input type="checkbox"/> (Select one)	Name Object :	
<input type="checkbox"/> Vehicle	Vehicle Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
<input type="checkbox"/> Object	Damage to Veh.:	Minimal / Moderate / Extensive / Totaled / Unsure
Impact Location		

During Impact Information:

Seat Belt?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Brakes Applied ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Air Bag Deployed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seat Broken ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seat Back position Changed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Head Rest : (Circle one)	Low / Mid / High / None
Prepare for Accident: (Circle One)	Un-expected / Expected / Expected and Braced
Body Position : (Circle one)	Straight / Rotated Left / Rotated Right / Unsure / Other:
Body Thrown?	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Direction of Throw :(Circle One)	Backwards / Forward / Outside / Unsure / Other:

(Circle One)

Head Position :	Straight / Rotated Left / Rotated Right / Forward / Unsure / Other:
Head Motion :	Forward Backwards / Backwards Forward / Right Left / Left Right / Unsure / Other:

Body Impact (Indicate any parts of your body that were struck during the impact)

<input type="checkbox"/> Head	<input type="checkbox"/> Upper Back	<input type="checkbox"/> Right hand	<input type="checkbox"/> Lower Back
<input type="checkbox"/> Left Shoulder	<input type="checkbox"/> Left Leg	<input type="checkbox"/> Mid Torso	<input type="checkbox"/> Right Foot
<input type="checkbox"/> Left Arm	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Mid Back	<input type="checkbox"/> Left Foot
<input type="checkbox"/> Left Elbow	<input type="checkbox"/> Right Shoulder	<input type="checkbox"/> Right Knee	<input type="checkbox"/> Other :
<input type="checkbox"/> Left hand	<input type="checkbox"/> Right Arm	<input type="checkbox"/> Left Knee	
<input type="checkbox"/> Upper Front Torso	<input type="checkbox"/> Right Elbow	<input type="checkbox"/> Lower Front Torso	

After Accident Information:

Immediately After Accident:	<input type="checkbox"/> Dizzy/dazed <input type="checkbox"/> Upset <input type="checkbox"/> Weak <input type="checkbox"/> Nervous <input type="checkbox"/> Headache <input type="checkbox"/> Disoriented <input type="checkbox"/> Unconscious
	<input type="checkbox"/> /Other:

Pain (Indicate if you experienced any pain immediately following the accident)

<input type="checkbox"/> Head	<input type="checkbox"/> Left foot	<input type="checkbox"/> Right foot	<input type="checkbox"/> Left Knee
<input type="checkbox"/> Left Hand	<input type="checkbox"/> Left Shoulder	<input type="checkbox"/> Right Shoulder	<input type="checkbox"/> Right knee
<input type="checkbox"/> Right Arm	<input type="checkbox"/> Left Elbow	<input type="checkbox"/> Left Arm	<input type="checkbox"/> Other :
<input type="checkbox"/> Upper Front Torso	<input type="checkbox"/> Mid Torso	<input type="checkbox"/> Right elbow	
<input type="checkbox"/> Upper Back	<input type="checkbox"/> Mid back	<input type="checkbox"/> Lower Front Torso	
<input type="checkbox"/> Left Leg	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Lower Back	

Numbness:	<input type="checkbox"/> Left Hand <input type="checkbox"/> Right Hand <input type="checkbox"/> Left Leg <input type="checkbox"/> Right Leg <input type="checkbox"/> Left Upper Arm
	<input type="checkbox"/> Right Upper Arm <input type="checkbox"/> Left Foot <input type="checkbox"/> Right Foot <input type="checkbox"/> Other:

Medical Information (Did you get medical care for this accident before coming to our office)

Medical Care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Time of care	Next day / At time of Accident / Later that Day / Days Later: (Specify)
Transported	Drove Self / Ambulance / Other
Went To	Orthopedic / Chiropractor / Neurologist / Family Doc / ER / Other:(Specify)
Admitted to Hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No Days Spent in Hospita:
Test:	<input type="checkbox"/> X-ray <input type="checkbox"/> Lab Work <input type="checkbox"/> MRI <input type="checkbox"/> CT Scan <input type="checkbox"/> Other:(Specify)
Treatment:	<input type="checkbox"/> Ice Pack <input type="checkbox"/> Hot Pack <input type="checkbox"/> None <input type="checkbox"/> Cervical Collar <input type="checkbox"/> Medication <input type="checkbox"/> Other:(Specify)

Previous Injuries

Previous Injuries / Accidents	<input type="checkbox"/> No <input type="checkbox"/> Yes, Specify:
Residual pain from Previous Injuries/Accidents	<input type="checkbox"/> No <input type="checkbox"/> Yes, Specify:

Later Symptoms (Please note any symptoms that started after the accident occurred)

Head	<input type="checkbox"/> Headache <input type="checkbox"/> Dizziness <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Light Headedness <input type="checkbox"/> Loss of Vision <input type="checkbox"/> Fainting <input type="checkbox"/> Loss of Memory <input type="checkbox"/> Pain in ear <input type="checkbox"/> Double Vision <input type="checkbox"/> Other Specify:
Neck (with Movement)	<input type="checkbox"/> Pain in Neck <input type="checkbox"/> Forward <input type="checkbox"/> Backward <input type="checkbox"/> Turn Left <input type="checkbox"/> Popping in Neck <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Turn Right <input type="checkbox"/> Bend Left <input type="checkbox"/> bend Right <input type="checkbox"/> Other Specify:
Shoulders	<input type="checkbox"/> Pain in Shoulder joint <input type="checkbox"/> Tension in shoulders <input type="checkbox"/> Muscle Spasms in Shoulder <input type="checkbox"/> Pain across shoulder <input type="checkbox"/> Cant raise arms above [] Above shoulder level [] Over head <input type="checkbox"/> Other Specify:
Arms and Hands	<input type="checkbox"/> Pain in Fingers <input type="checkbox"/> Numbness in Left Arm <input type="checkbox"/> Hands Cold <input type="checkbox"/> Pin & needles in hands <input type="checkbox"/> Numbness in Right Arm <input type="checkbox"/> Loss of Grip Strength <input type="checkbox"/> Pin & needles in fingers <input type="checkbox"/> Swollen joints in Fingers <input type="checkbox"/> Other Specify:
Chest	<input type="checkbox"/> Chest pain <input type="checkbox"/> Pain Around Ribs <input type="checkbox"/> Shortness of Breadth <input type="checkbox"/> Breast Pain <input type="checkbox"/> Other Specify:
Abdomen	<input type="checkbox"/> Nervous Stomach <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Gas <input type="checkbox"/> Constipation <input type="checkbox"/> Other Specify:
Mid back	<input type="checkbox"/> Sharp Stabbing <input type="checkbox"/> Mid pain back <input type="checkbox"/> Pain From front to back <input type="checkbox"/> Dull Ache <input type="checkbox"/> Pain in Kidney Area <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Pain between shoulders <input type="checkbox"/> Other Specify:
Lower Back	<input type="checkbox"/> Low Back Pain Low back pain is worse when <input type="checkbox"/> Working <input type="checkbox"/> Lifting <input type="checkbox"/> Stooping <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Bending <input type="checkbox"/> Coughing <input type="checkbox"/> Lying Down <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Other Specify:
Hips, Legs & Feet	<input type="checkbox"/> Pain in Buttocks <input type="checkbox"/> Pain and needles in Legs <input type="checkbox"/> Pain down leg <input type="checkbox"/> Pain in hip joint <input type="checkbox"/> Feet feel Cold <input type="checkbox"/> Swollen Feet <input type="checkbox"/> Numbness in Toes <input type="checkbox"/> Numbness of Leg <input type="checkbox"/> Knee pain <input type="checkbox"/> Leg cramps <input type="checkbox"/> Cramps in Feet <input type="checkbox"/> Other Specify:
General	<input type="checkbox"/> Nervousness <input type="checkbox"/> Fatigue <input type="checkbox"/> Irritable <input type="checkbox"/> Depressed <input type="checkbox"/> Generally Feel Rundown <input type="checkbox"/> Prostate Pain/Swelling <input type="checkbox"/> Difficulty Urinating <input type="checkbox"/> Night Urination <input type="checkbox"/> Cramping <input type="checkbox"/> Irregularity Loss of Sleep : [_____] hrs per night Loss of weight : [_____]Lbs Gain weight : [_____] Lbs Other:

Signature: _____

Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.