PATIENT INJURY/MEDICAL HISTORY FORM

Name _____ Date_____

Date of Incident:_____ Time: _____ Location: _____

Type of Accident You Were Involved In: ☐ Work ☐ Sports ☐ Auto ☐ Personal Injury ☐ Other

VEHICLES INVOLVED (If Applicable)

Your Vehicle: Year _____ Make _____ Model _____

Other Vehicle: Year_____ Make _____ Model _____

Damage to Your Vehicle: $_____ Other Vehicle Damage:$_____

SPECIFICS OF ACCIDENT

I was the ☐ Driver ☐Passenger
I was sitting ☐Front, Left ☐Front, Right ☐Back, Left ☐Back, Right ☐ Wearing Seat Belt ☐ Air Bag Deployed ☐ Struck Headrest ☐ Facing Front ☐ Turned

Were other people in the car? ☐ Yes ☐ No
If yes, were they injured? ☐ Yes ☐ No
Were police notified? ☐ Yes ☐ No

Impending Collision: ☐Aware ☐Unaware ☐Braced ☐Not braced

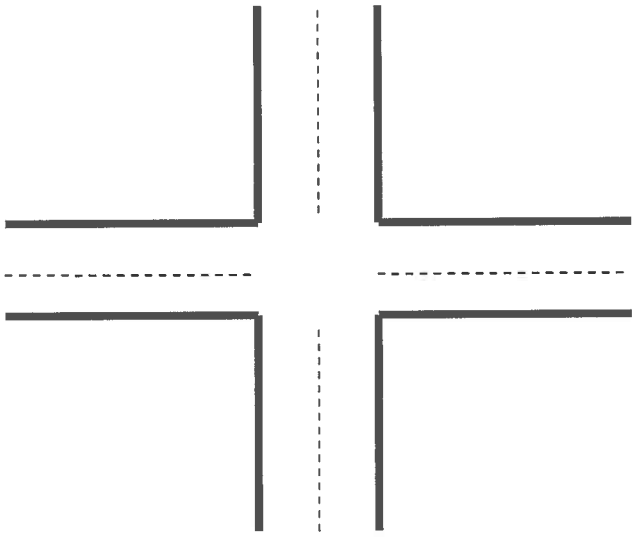
Experienced: ☐Shock ☐Loss of Consciousness ☐Flash of Light Seen Upon Impact

The road was: ☐ Dry ☐ Wet ☐ Icy ☐ Snowy

The Weather Conditions Were: ☐ Sunny ☐ Cloudy ☐ Foggy ☐ Light Rain ☐ Heavy Rain ☐ Snowing

Time of Day Accident Occurred: ☐Dawn ☐Day ☐Dusk ☐Night ☐Unknown

Please illustrate the accident with all involved vehicles (if applicable) below:



Please describe the accident:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

IMMEDIATELY FOLLOWING THE ACCIDENT

☐Ambulance – Paramedics Called ☐ Treated at Scene ☐ Transported to Hospital by Ambulance
☐ Went to Hospital on their Own ☐ Diagnostics Performed at Hospital ☐ Treatment at Hospital
☐Medication Prescribed ☐Follow-up Recommended

Where were you taken after the accident and who cared for you?

Were X-Rays, MRI or other tests done? ☐ Yes ☐ No

If yes, please list: _____

What was the treatment provided? _____

Are you currently receiving care from other health professionals? ☐ Yes ☐ No

If yes, please give name, specialty, and contact information. _____

_____

INJURIES FROM THE ACCIDENT

As a result of the accident, did you have any of the following? *Please check all that apply.*

☐ Broken bones	☐ Dislocations	☐ Head Injuries	☐ Surgery	☐ Concussion
☐ Dizziness	☐ Stiff neck	☐ Memory Loss	☐ Nausea	☐ Buzzing/Ringing in Ears
☐ Tension	☐ Upset stomach	☐ Blurred Vision	☐ Chest Pain	☐ Arm/Shoulder Pain
☐ Back Stiffness	☐ Neck Pain	☐ Headaches	☐ Jaw Pain	☐ Forgetfulness
☐ Irritability	☐ Back Pain	☐ Fatigue	☐ Leg Pain	☐ Numb Feet/Toes
☐ Disturbed sleep	☐ Shortness of Breath	☐ Other _____		

The pain started _____
The pain is made better by _____
and worse by _____
The pain has the following qualities: _____
☐There is ☐There is not radiation into _____
☐There is ☐There is not referred pain into_____
☐ There is ☐ There is not parasthesia (tingling/numbness) into:_____
The pain is located _____
The pain is (as far as timing concerned: i.e. comes & goes, constant, etc.) _____

PAIN RATING

On a scale of 1-10, 10 being the worst _____

The overall severity of the pain is described as: ☐ Mild Nuisance ☐ Mild to moderate ☐ Moderate – Having trouble coping ☐ Severe – Ruining quality of life

Other Doctors Seen:

☐Orthopedist ☐Neurologist ☐Psychiatrist ☐Chiropractor ☐Massage Therapist ☐Physical Therapist

FEMALES ONLY – Please mark if you have any of the following

☐ Vaginal bleeding other than menstrual period
☐ Pap smear within last two years
☐ Painful menstrual periods
☐ Back pain with menstrual periods
☐ Other menstrual problems

Do you have a home exercise program that you follow on a regular basis? ☐ Yes ☐ No

In general, how would you rate your health?
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Compared to one year ago, how would you rate your health in general now?
☐ Much better than one year ago
☐ Somewhat better now than one year ago
☐ About the same
☐ Somewhat worse now than one year ago
☐ Much worse now than one year ago

The following items are about activities you might do during a typical day. Please indicate if your current health now limits you in these activities, and if so, how much.

	Limited a Lot	Limited a Little	Not Limited
Vigorous activities such as running, lifting heavy objects, participating in strenuous sports	☐	☐	☐
Moderate activities such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
Lifting or carrying groceries	☐	☐	☐
Climbing several flights of stairs	☐	☐	☐
Climbing one flight of stairs	☐	☐	☐
Bending, kneeling, or stooping	☐	☐	☐
Walking more than a mile	☐	☐	☐
Walking several blocks	☐	☐	☐
Walking one block	☐	☐	☐
Bathing or dressing yourself	☐	☐	☐

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 your physical health?

Cut down the amount of time you spent on work or other activities	☐ Yes	☐ No
Accomplished less than you would like	☐ Yes	☐ No
Were limited in the kind of work or other activities	☐ Yes	☐ No
Had difficulty perform work or other activities	☐ Yes	☐ 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)*

Cut down the amount of time you spend on work or other activities	☐ Yes	☐ No
Accomplished less than you would like	☐ Yes	☐ No
Didn't do work or other activities as carefully as usual	☐ Yes	☐ No

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

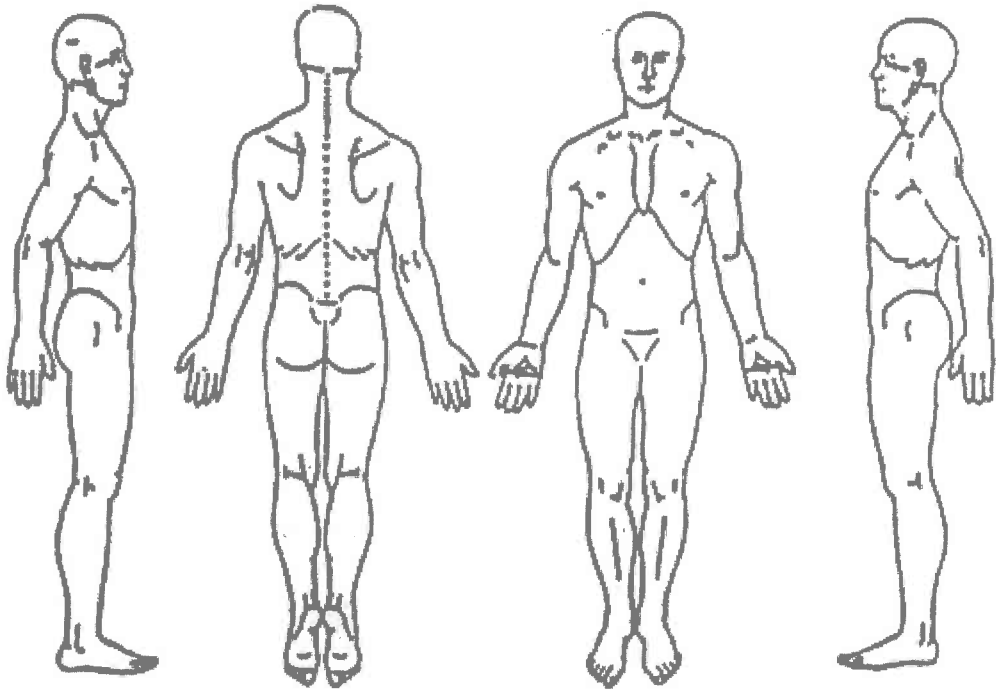
☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a Bit ☐ Extremely

LOW BACK PAIN DISABILITY QUESTIONNAIRE

How long have you been experiencing low back pain? _____
Is this your first episode of low back pain?

Use the letters below to indicate the type and location of your sensations right now:

A = Aches **B** = Burning **N** = Numbness **P** = Pins & Needles **S** = Stabbing **O** = Other



Additional Comments:

_____

_____

_____

_____

State your emotions and physical states *Immediately Following* the accident:

_____

_____

State your Emotion & Physical State in the days following the accident _____

_____

INTERFERENCE WITH DAILY ACTIVITIES

How many days out of the week do you have pain? _____

How much time out of the day are you in pain? _____

What are the worst times of the day for the pain? _____

How do the following activities affect your pain?

	No Change	Relieves	Increased	Duration
Sitting	☐	☐	☐	_____
Walking	☐	☐	☐	_____
Standing	☐	☐	☐	_____
Lying Down	☐	☐	☐	_____
Looking Up	☐	☐	☐	_____
Looking Down	☐	☐	☐	_____
Lifting	☐	☐	☐	_____

Please mark each that apply to your Daily Living Activities since the accident:

☐ Stays at home most of the time due to the pain
☐ Changes positions frequently to try and get comfortable
☐ Walks slower than usual because of the pain
☐ Does not do jobs around the house because of the pain
☐ Has to use handrails to get up stairs, etc.
☐ Has to lie down and rest frequently due to the pain
☐ Has to hold onto something to sit or stand from a chair
☐ Has to get other people to do things for you
☐ Can only stand for short periods due to the pain
☐ Has difficulty bending or kneeling due to the pain
☐ Has difficulty turning over in bed due to the pain
☐ Has a loss of appetite due to the pain
☐ Can only walk short distances because of the pain
☐ Has difficulty sleeping because of the pain
☐ Has to get dressed with someone's help
☐ Has to sit most of the day because of the pain
☐ Has become more irritable because of the pain
☐ Has difficulty climbing stairs
☐ Stays in bed most of the day because of the pain

What are some recreational activities that you participated in before the accident that you are unable to perform now to the same extent? _____

_____

_____

_____

_____

How often do you have to stop activities and sit or lie down to control your symptoms?

☐ Several times a day
☐ Occasionally
☐ Approximately once per day
☐ Never
☐ All day

SOCIAL HISTORY

☐ Single
☐ Married
☐ Divorced
☐ Number of Children

☐ Smoker
☐ Non-Smoker
☐ Drinks Alcohol
☐ Does not drink Alcohol

☐ Takes drugs
☐ Does not take drugs

OCCUPATIONAL HISTORY

Employer _____

Job Title _____

Are your job duties physically demanding for you?	☐ Yes	☐ No
Have you had any disability time?	☐ Yes	☐ No
If you are currently working, which are you performing?	☐ Regular Duties	☐ Limited-Light Duties

MEDICAL HISTORY

Please list other Physicians and Health Practitioners you have seen for injuries as a result of the accident:

_____

_____

List of Medications you are currently taking: (Prescription and over the counter)

_____

_____

List of treatments you have had for your injuries from the accident:

☐ Hot Pack/Ultrasound	☐ Chiropractic	☐ Massage	☐ Osteopathy
☐ Electrical Stimulation	☐ Biofeedback	☐ TENS Unit	☐ Trigger Point
☐ Body Mechanics Training	☐ Epidural Injections	☐ Aerobics	☐ Acupuncture
☐ Strengthening Exercises	☐ Back Brace	☐ Naturopathy	☐ Bed Rest
☐ Gravity Inversion-Traction			

List the type of Diagnostic Testing that has been performed for the injuries from your accident:

☐ X-Rays	☐ Discogram	☐ CT Scan	☐ Bone San
☐ Myelogram	☐ EMG	☐ MRI Scan	

List past surgeries, if applicable: _____

_____

List past hospitalizations, if applicable: _____

_____

List any previous back, neck, and musculoskeletal problems you have had:

_____

_____

Indicate any of the symptoms you had had in the past 5 years:

☐ Unexplained fevers	☐ Swollen ankles	☐ Stomach pain
☐ Weight loss of 10 lbs or more	☐ Change in bowel habits	☐ Loss of appetite
☐ Persistent diarrhea	☐ Excessive fatigue	☐ Excessive constipation
☐ Depression	☐ Dark black stools	☐ Difficulty sleeping
☐ Blood in stools	☐ Unusual stress at work	☐ Pain-burning when urinating
☐ Easy bruising	☐ Need to urinate more at night	☐ Lumps in neck, armpit, or groin
☐ Morning stiffness	☐ Chest pain or tightness	☐ Persistent eye redness
☐ Persistent or unusual cough	☐ Muscle tenderness	☐ Trouble breathing with exercise
☐ Dry eyes or mouth	☐ Trouble breathing lying flat	☐ Skin rashes
☐ Coughing up blood	☐ Joint pain or swelling	

Please indicate if you are currently experience the following:

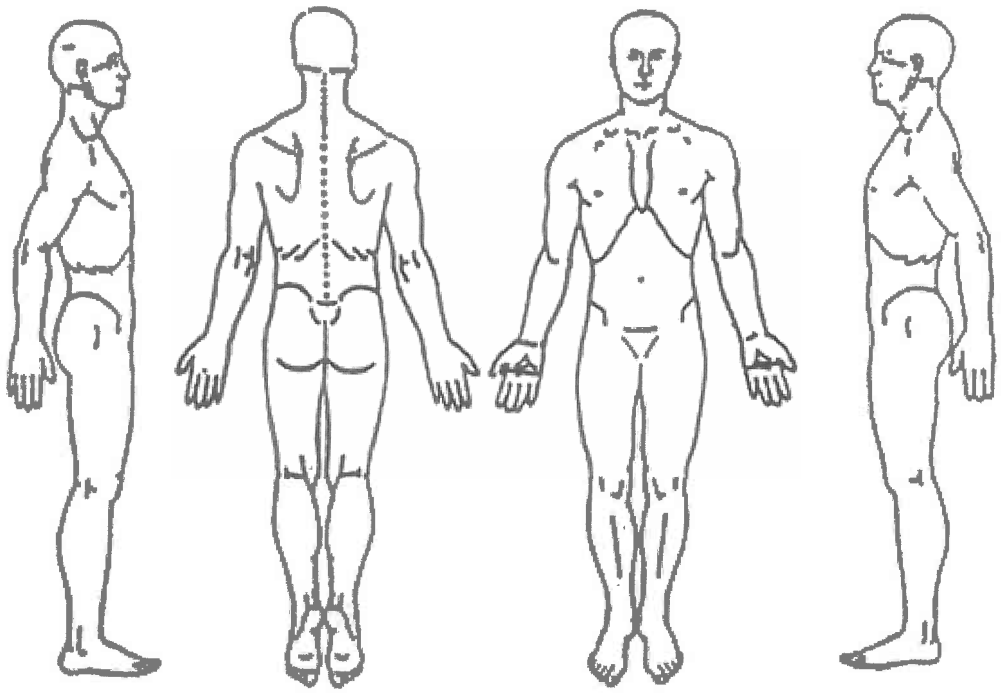
☐ Anxiety ☐ Depression ☐ Irritability

NECK PAIN DISABILITY QUESTIONNAIRE

How long have you been experiencing neck pain? _____
Is this your first episode of neck pain?

Use the letters below to indicate the type and location of your sensations right now:

A = Aches **B** = Burning **N** = Numbness **P** = Pins & Needles **S** = Stabbing **O** = Other



Additional Comments:

_____

_____

_____

_____