ACCIDENT HISTORY 1

Patient's Name: _____ Today's Date: _____
Date of Injury: _____ Birthdate: _____

Specifics of Accident:

___ Job or Work Related Injury
___ Front Seat Passenger
___ Motorcycle Driver/Passenger
___ No Seatbelt
___ Unaware of Impending Collision
___ Not Braced
___ Head Did Not Strike Object
___ Loss of Consciousness
___ Flash of Light Seen Upon Impact
___ Driver
___ Back Seat Passenger
___ Seat belted
___ Aware of Impending Collision
___ Braced
___ Head Did Strike Object
___ Shock
___ Air Bag Deployed

Your Vehicle (year, make, model): _____
Your Estimated Speed at the time of Crash: _____
Other Vehicle (year, make, model): _____

Road Conditions:

___ Dry ___ Icy
___ Wet ___ Snowy

Weather Conditions:

___ Sunny ___ Light Rain
___ Cloudy ___ Heavy Rain
___ Foggy ___ Snowing

Time of Day:

___Dawn ___ Day ___ Dusk ___ Night ___ Unknown

Patient's Description of Accident:

_____
_____
_____
_____
_____

Emotions and Physical State Immediately Following the Accident:

_____
_____
_____

ACCIDENT HISTORY 2

Immediately Following the Accident:

___ Ambulance/Paramedics Called to Scene
___ Treated at Scene
___ Transported to Hospital by Ambulance
___ Went to Hospital on His/Her Own
___ Diagnostics Performed at Hospital
___ Treatment at Hospital
___ Medication Prescribed
___ Follow-up Recommended

Other Practitioners Seen:

___ Orthopedist
___ Massage Therapist
___ Physical Therapist
___ Other Practitioner
___ Psychiatrist/Psychologist
___ Neurologist
___ Other Chiropractor

After Accident/Hospital and First Few Days after Accident:

Patient Signature_____ **Date**_____

DAILY ACTIVITIES 1

How many days out of an average week do your have pain?_____
How much of the time out of an average day are you in pain?_____
What are the worst times of the day for the pain?_____
What are the best times of day for the pain? _____

How do the following activities affect your pain?

	No Change	Relieves	Increases	Duration
Sitting				
Walking				
Standing				
Lying Down				
Looking Up				
Looking Down				
Lifting				

What do you do to relieve the pain?

_____
_____

Rating:

Rate your pain on a scale of 1 – 10 (10 being the worst):

_____
_____

How do you describe the overall severity of the pain?

___ Mild Nuisance
___ Mild to Moderate but can live with it
___ Moderate, having trouble dealing with it
___ Severe, it is ruining my quality of life

Progression:
How is your pain compared to when the pain episode first started?

___ Much Improved ___ A Little Worse ___ Somewhat Improved
___ Much Worse ___ No Change

DAILY ACTIVITIES 2

Your Daily Living:

___ Stay at home most of the time due to the problem
___ Change positions frequently to try and get comfortable
___ Walk more slowly than usual because of the problem
___ Do not do jobs around the house because of the problem
___ Have to use handrails to get up stairs
___ Have to lie down and rest frequently due to the problem
___ Have to hold onto something to sit or stand from a chair
___ Have to get other people to do things for me
___ Have difficulty getting dressed due to the problem
___ Can only stand for short periods due to the problem
___ Have difficulty bending or kneeling due to the problem
___ Have difficulty turning over in bed due to the problem
___ Have a loss of appetite due to this problem
___ Can only walk short distances because of the problem
___ Have difficulty sleeping because of the problem
___ Have to get dressed with someone's help
___ Have to sit most of the day because of the problem
___ Am more irritable because of the problem
___ Have difficulty climbing stairs
___ Stay in bed most of the day because of the problem

What are some recreational activities that you participated in before this current problem and which ones you not perform now to the same extent as before?

_____
_____
_____
_____
_____

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

___ Several Times a Day ___ Occasionally ___ Never
___ Approximately once per Day ___ All Day

SYMPTOMATOLOGY

Pain Characteristics for Major Area of Complaint:

The Pain Started:

The Pain is made better by:

and made worse by:

The Pain has the following qualities:

___ There is Radiation ___ There is not radiation into

___ There is ___ There is not referred pain into

___ There is ___ There is not paresthesia into

___ The pain is located

The pain is (as far as timing is concerned):

SOCIAL/OCCUPATIONAL HISTORY

Social History: (please check all that apply)

___ Single ___ Married ___ Divorced Number of Children ___

___ Smoker ___ Non-Smoker ___ Drink Alcohol ___ Do Not Drink Alcohol

___ Take Drugs ___ Do Not Take Drugs

Participate in the following Hobbies/Exercises:

_____

_____

_____

Occupational History: (please check all that apply)

Patient's Employer _____
Job Position/Title _____

___ Physically Demanding Work
___ Regular Duties
___ Any Disability Time
___ Limited/Light Duties

Your Job Satisfaction:

___ Very Satisfied ___ Satisfied ___ Dissatisfied ___ Very Dissatisfied

Education Completed (Highest level of education attained):

_____

_____

MEDICAL HISTORY 1

You have seen the following physicians and other practitioners for your current problems:

_____

_____

_____

You have received the following treatments for your problems:

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

You have had surgery for:

_____

_____

_____

You have been hospitalized for:

_____

_____

_____

You are taking the following medication(s):

_____

_____

_____

___ You have not had any surgery ___ You have not had any hospitalization
___ You are not taking any medication(s)

Number of Pregnancies ___

The following types of Diagnostic Testing have been performed on you:

___ X-rays ___ CT Scan ___ Myelogram ___ MRI Scan
___ Discogram ___ Bone Scan ___ EMG ___ Other:

You have had the following previous back, neck and musculoskeletal problems:

_____

_____

MEDICAL HISTORY 2

You have had the following symptoms in the past 5 years:

___ Unexplained Fevers
___ Night Sweats
___ Weight Loss of 10 lbs or more
___ Loss of Appetite
___ Excessive Fatigue
___ Problems with Depression
___ Difficulty Sleeping
___ Unusual Stress at Work
___ Unusual Stress at Home
___ Easy Bruising
___ Excessive Bleeding
___ Morning Stiffness
___ Chest Pains or Tightness
___ Persistent or Unusual Cough
___ Dry Eyes or Mouth
___ Skin Rashes
___ Coughing Up Blood
___ Other:

___ Swollen Ankles
___ Stomach Pain
___ Change in Bowel Habits
___ Persistent Diarrhea
___ Excessive Constipation
___ Dark Black Stools
___ Blood in Stools
___ Pain/Burning when Urinating
___ Difficulty Urinating – start/stop
___ Blood in Urine
___ Need to Urinate More at Night
___ Lumps in Neck, Armpit or Groin
___ Persistent Eye Redness
___ Muscle Tenderness
___ Trouble Breathing with Exercise
___ Trouble Breathing Lying Flat
___ Joint Pain or Swelling

Females:

___ Vaginal Bleeding other than period
___ Pap Smear within last two years
___ Painful Menstrual Periods
___ Back Pain with Menstrual Periods
___ Other Menstrual Problems:

You feel you have trouble with:

___ Anxiety ___ Depression ___ Irritability

Exercise Program:

___ You have a home exercise program that you follow on a regular basis.
___ You do not have a home exercise program that you follow on a regular basis.

Patient Signature: _____ Date: _____