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: ☐ Right ☐ Left ☐ 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.

Patient Sign & Date:________________________ **Date:**____________________

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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	2. Your position in vehicle	3. What was your vehicle doing at the time of the accident?
☐ Car ☐ Station Wagon ☐ Van ☐ Pickup Truck ☐ Large Truck ☐ Bus Other________	☐ Driver ☐ Front Passenger ☐ Left Rear Passenger ☐ Right Rear Passenger Other________	☐ 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	5. Details of Accident	6. Road conditions
Time of accident________ Your vehicle's speed: ________mph Their vehicle's speed: ________mph **Damage to your vehicle** ☐ Mild ☐ Moderate ☐ Totaled	**Visibility at time of accident** ☐ Poor ☐ Fair ☐ Good **Who hit who/what?** ☐ You hit other vehicle ☐ Other vehicle hit you **You hit...(object)** ________	**Road conditions at time of accident** ☐ Icy ☐ Wet ☐ Sandy ☐ Dark ☐ Clean and dry **Point of impact** ☐ Head-On ☐ Left Front ☐ Right Front ☐ Rear-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: ___/___/___

Patient Sign & Date:________ **Date:**________

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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.

1. Check only one body location below

Location	L	R	B
❑Headaches	❑	❑	❑
❑Front of Head			
❑Top of Head			
❑Back of Head			
❑Jaw	❑	❑	❑
❑Eye	❑	❑	❑
❑Neck	❑	❑	❑
❑Upper Back	❑	❑	❑
❑Mid Back	❑	❑	❑
❑Low Back	❑	❑	❑
❑Chest	❑	❑	❑
❑Abdomen	❑	❑	❑
❑Ribs	❑	❑	❑
❑Buttocks	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Upper Arm	❑	❑	❑
❑Forearm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations:____________

2. Types of pain

❑ Dull ❑ Sharp ❑ Aching ❑ Cutting
❑Throbbing ❑ Burning ❑ Numbing ❑ Tingling ❑ Cramping
❑Spasm ❑ Stinging ❑ Shooting ❑ Pounding ❑Constricting

Other types of pain: ____________ ____________

3. Pain Frequency

❑Up to 1/4 of awake time ❑1/4 to 1/2 of time
❑1/2 to 3/4 of awake time ❑ Most all the time

4. Pain Intensity (How it affects your daily activites)

❑ Doesn't affect ❑ Somewhat affects
❑ Seriously affects ❑ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑ Head	❑	❑	❑
❑ Neck	❑	❑	❑
❑ Shoulder	❑	❑	❑
❑ Arm	❑	❑	❑
❑ Hand	❑	❑	❑
❑ Hip	❑	❑	❑
❑ Leg	❑	❑	❑
❑ Foot	❑	❑	❑

Other locations of radiation:____________

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑ In the A.M.	❑	❑	❑
❑ In the P.M.	❑	❑	❑
❑ Bending forward	❑	❑	❑
❑ Bending back	❑	❑	❑
❑ Bending left	❑	❑	❑
❑ Bending right	❑	❑	❑
❑ Twisting left	❑	❑	❑
❑ Twisting right	❑	❑	❑
❑ Coughing	❑	❑	❑
❑ Sneezing	❑	❑	❑
❑ Straining	❑	❑	❑
❑ Standing	❑	❑	❑
❑ Sitting	❑	❑	❑
❑ Lifting	❑	❑	❑
Other Actions:	❑	❑	❑
____________	❑	❑	❑

II. Second Current Symptom: (Please check off the boxes below to describe your next symptom).

1. Check only one body location below

Location	L	R	B
❑Headaches	❑	❑	❑
❑Front of Head			
❑Top of Head			
❑Back of Head			
❑Jaw	❑	❑	❑
❑Eye	❑	❑	❑
❑Neck	❑	❑	❑
❑Upper Back	❑	❑	❑
❑Mid Back	❑	❑	❑
❑Low Back	❑	❑	❑
❑Chest	❑	❑	❑
❑Abdomen	❑	❑	❑
❑Ribs	❑	❑	❑
❑Buttocks	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Upper Arm	❑	❑	❑
❑Forearm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations:____________

2. Types of pain

❑ Dull ❑ Sharp ❑ Aching ❑ Cutting
❑Throbbing ❑ Burning ❑ Numbing ❑ Tingling ❑ Cramping
❑Spasm ❑ Stinging ❑ Shooting ❑ Pounding ❑Constricting

Other types of pain: ____________ ____________

3. Pain Frequency

❑Up to 1/4 of awake time ❑1/4 to 1/2 of time
❑1/2 to 3/4 of awake time ❑ Most all the time

4. Pain Intensity (How it affects your daily activites)

❑ Doesn't affect ❑ Somewhat affects
❑ Seriously affects ❑ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑ Head	❑	❑	❑
❑ Neck	❑	❑	❑
❑ Shoulder	❑	❑	❑
❑ Arm	❑	❑	❑
❑ Hand	❑	❑	❑
❑ Hip	❑	❑	❑
❑ Leg	❑	❑	❑
❑ Foot	❑	❑	❑

Other locations of radiation:____________

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑ In the A.M.	❑	❑	❑
❑ In the P.M.	❑	❑	❑
❑ Bending forward	❑	❑	❑
❑ Bending back	❑	❑	❑
❑ Bending left	❑	❑	❑
❑ Bending right	❑	❑	❑
❑ Twisting left	❑	❑	❑
❑ Twisting right	❑	❑	❑
❑ Coughing	❑	❑	❑
❑ Sneezing	❑	❑	❑
❑ Straining	❑	❑	❑
❑ Standing	❑	❑	❑
❑ Sitting	❑	❑	❑
❑ Lifting	❑	❑	❑
Other Actions:	❑	❑	❑
____________	❑	❑	❑

III. Third Current Symptom: (Please check off the boxes below to describe your 3rd symptom).

1. Check only one body location below

Location	L	R	B
❑Headaches	❑	❑	❑
❑Front of Head			
❑Top of Head			
❑Back of Head			
❑Jaw	❑	❑	❑
❑Eye	❑	❑	❑
❑Neck	❑	❑	❑
❑Upper Back	❑	❑	❑
❑Mid Back	❑	❑	❑
❑Low Back	❑	❑	❑
❑Chest	❑	❑	❑
❑Abdomen	❑	❑	❑
❑Ribs	❑	❑	❑
❑Buttocks	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Upper Arm	❑	❑	❑
❑Forearm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations:____________

2. Types of pain

❑ Dull ❑ Sharp ❑ Aching ❑ Cutting
❑Throbbing ❑ Burning ❑ Numbing ❑ Tingling ❑ Cramping
❑Spasm ❑ Stinging ❑ Shooting ❑ Pounding ❑Constricting

Other types of pain: ____________ ____________

3. Pain Frequency

❑Up to 1/4 of awake time ❑1/4 to 1/2 of time
❑1/2 to 3/4 of awake time ❑ Most all the time

4. Pain Intensity (How it affects your daily activites)

❑ Doesn't affect ❑ Somewhat affects
❑ Seriously affects ❑ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑ Head	❑	❑	❑
❑ Neck	❑	❑	❑
❑ Shoulder	❑	❑	❑
❑ Arm	❑	❑	❑
❑ Hand	❑	❑	❑
❑ Hip	❑	❑	❑
❑ Leg	❑	❑	❑
❑ Foot	❑	❑	❑

Other locations of radiation:____________

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑ In the A.M.	❑	❑	❑
❑ In the P.M.	❑	❑	❑
❑ Bending forward	❑	❑	❑
❑ Bending back	❑	❑	❑
❑ Bending left	❑	❑	❑
❑ Bending right	❑	❑	❑
❑ Twisting left	❑	❑	❑
❑ Twisting right	❑	❑	❑
❑ Coughing	❑	❑	❑
❑ Sneezing	❑	❑	❑
❑ Straining	❑	❑	❑
❑ Standing	❑	❑	❑
❑ Sitting	❑	❑	❑
❑ Lifting	❑	❑	❑
Other Actions:	❑	❑	❑
____________	❑	❑	❑

Patient Sign & Date:____________________ **Date:**____________________

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Description of Symptoms

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

IV. Fourth Symptom:

(Please check off the boxes below to describe your 4th symptom. Describe only ONE symptom per Section.)

1. Check only one body location below

Location	L	R	B
☐ Headaches	☐	☐	☐
☐ Front of Head			
☐ Top of Head			
☐ Back of Head			
☐ Jaw	☐	☐	☐
☐ Eye	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Upper Back	☐	☐	☐
☐ Mid Back	☐	☐	☐
☐ Low Back	☐	☐	☐
☐ Chest	☐	☐	☐
☐ Abdomen	☐	☐	☐
☐ Ribs	☐	☐	☐
☐ Buttocks	☐	☐	☐
☐ Shoulder	☐	☐	☐
☐ Upper Arm	☐	☐	☐
☐ Forearm	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Hip	☐	☐	☐
☐ Leg	☐	☐	☐
☐ Foot	☐	☐	☐

Other locations:____________________

2. Types of pain

☐ Dull ☐ Sharp ☐ Aching ☐ Cutting
☐ Throbbing ☐ Burning ☐ Numbing ☐ Tingling ☐ Cramping
☐ Spasm ☐ Stinging ☐ Shooting ☐ Pounding ☐ Constricting

Other types of pain: ________________ ________________

3. Pain Frequency

☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time
☐ 1/2 to 3/4 of awake time ☐ Most all the time

4. Pain Intensity (How it affects your daily activites)

☐ Doesn't affect ☐ Somewhat affects
☐ Seriously affects ☐ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
☐ Head	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Shoulder	☐	☐	☐
☐ Arm	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Hip	☐	☐	☐
☐ Leg	☐	☐	☐
☐ Foot	☐	☐	☐

Other locations of radiation:________________

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
☐ In the A.M.	☐	☐	☐
☐ In the P.M.	☐	☐	☐
☐ Bending forward	☐	☐	☐
☐ Bending back	☐	☐	☐
☐ Bending left	☐	☐	☐
☐ Bending right	☐	☐	☐
☐ Twisting left	☐	☐	☐
☐ Twisting right	☐	☐	☐
☐ Coughing	☐	☐	☐
☐ Sneezing	☐	☐	☐
☐ Straining	☐	☐	☐
☐ Standing	☐	☐	☐
☐ Sitting	☐	☐	☐
☐ Lifting	☐	☐	☐
Other Actions:			
____________	☐	☐	☐
	☐	☐	☐

V. Fifth Current Symptom:

(Please check off the boxes below to describe your 5th symptom).

1. Check only one body location below

Location	L	R	B
☐ Headaches	☐	☐	☐
☐ Front of Head			
☐ Top of Head			
☐ Back of Head			
☐ Jaw	☐	☐	☐
☐ Eye	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Upper Back	☐	☐	☐
☐ Mid Back	☐	☐	☐
☐ Low Back	☐	☐	☐
☐ Chest	☐	☐	☐
☐ Abdomen	☐	☐	☐
☐ Ribs	☐	☐	☐
☐ Buttocks	☐	☐	☐
☐ Shoulder	☐	☐	☐
☐ Upper Arm	☐	☐	☐
☐ Forearm	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Hip	☐	☐	☐
☐ Leg	☐	☐	☐
☐ Foot	☐	☐	☐

Other locations:____________________

2. Types of pain

☐ Dull ☐ Sharp ☐ Aching ☐ Cutting
☐ Throbbing ☐ Burning ☐ Numbing ☐ Tingling ☐ Cramping
☐ Spasm ☐ Stinging ☐ Shooting ☐ Pounding ☐ Constricting

Other types of pain: ________________ ________________

3. Pain Frequency

☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time
☐ 1/2 to 3/4 of awake time ☐ Most all the time

4. Pain Intensity (How it affects your daily activites)

☐ Doesn't affect ☐ Somewhat affects
☐ Seriously affects ☐ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
☐ Head	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Shoulder	☐	☐	☐
☐ Arm	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Hip	☐	☐	☐
☐ Leg	☐	☐	☐
☐ Foot	☐	☐	☐

Other locations of radiation:________________

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
☐ In the A.M.	☐	☐	☐
☐ In the P.M.	☐	☐	☐
☐ Bending forward	☐	☐	☐
☐ Bending back	☐	☐	☐
☐ Bending left	☐	☐	☐
☐ Bending right	☐	☐	☐
☐ Twisting left	☐	☐	☐
☐ Twisting right	☐	☐	☐
☐ Coughing	☐	☐	☐
☐ Sneezing	☐	☐	☐
☐ Straining	☐	☐	☐
☐ Standing	☐	☐	☐
☐ Sitting	☐	☐	☐
☐ Lifting	☐	☐	☐
Other Actions:			
____________	☐	☐	☐
	☐	☐	☐

VI. Sixth Current Symptom:

(Please check off the boxes below to describe your 6th symptom).

1. Check only one body location below

Location	L	R	B
☐ Headaches	☐	☐	☐
☐ Front of Head			
☐ Top of Head			
☐ Back of Head			
☐ Jaw	☐	☐	☐
☐ Eye	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Upper Back	☐	☐	☐
☐ Mid Back	☐	☐	☐
☐ Low Back	☐	☐	☐
☐ Chest	☐	☐	☐
☐ Abdomen	☐	☐	☐
☐ Ribs	☐	☐	☐
☐ Buttocks	☐	☐	☐
☐ Shoulder	☐	☐	☐
☐ Upper Arm	☐	☐	☐
☐ Forearm	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Hip	☐	☐	☐
☐ Leg	☐	☐	☐
☐ Foot	☐	☐	☐

Other locations:____________________

2. Types of pain

☐ Dull ☐ Sharp ☐ Aching ☐ Cutting
☐ Throbbing ☐ Burning ☐ Numbing ☐ Tingling ☐ Cramping
☐ Spasm ☐ Stinging ☐ Shooting ☐ Pounding ☐ Constricting

Other types of pain: ________________ ________________

3. Pain Frequency

☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time
☐ 1/2 to 3/4 of awake time ☐ Most all the time

4. Pain Intensity (How it affects your daily activites)

☐ Doesn't affect ☐ Somewhat affects
☐ Seriously affects ☐ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
☐ Head	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Shoulder	☐	☐	☐
☐ Arm	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Hip	☐	☐	☐
☐ Leg	☐	☐	☐
☐ Foot	☐	☐	☐

Other locations of radiation:________________

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
☐ In the A.M.	☐	☐	☐
☐ In the P.M.	☐	☐	☐
☐ Bending forward	☐	☐	☐
☐ Bending back	☐	☐	☐
☐ Bending left	☐	☐	☐
☐ Bending right	☐	☐	☐
☐ Twisting left	☐	☐	☐
☐ Twisting right	☐	☐	☐
☐ Coughing	☐	☐	☐
☐ Sneezing	☐	☐	☐
☐ Straining	☐	☐	☐
☐ Standing	☐	☐	☐
☐ Sitting	☐	☐	☐
☐ Lifting	☐	☐	☐
Other Actions:			
____________	☐	☐	☐
	☐	☐	☐

Patient Sign & Date:____________________________ **Date:**____________________

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Description of Symptoms

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

VII. Seventh Symptom:
(Please check off the boxes below to describe your 7th symptom. Describe only ONE symptom per Section.)

1. Check only one body location below

Location	L	R	B
☐Headaches	☐	☐	☐
☐Front of Head			
☐Top of Head			
☐Back of Head			
☐Jaw	☐	☐	☐
☐Eye	☐	☐	☐
☐Neck	☐	☐	☐
☐Upper Back	☐	☐	☐
☐Mid Back	☐	☐	☐
☐Low Back	☐	☐	☐
☐Chest	☐	☐	☐
☐Abdomen	☐	☐	☐
☐Ribs	☐	☐	☐
☐Buttocks	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Upper Arm	☐	☐	☐
☐Forearm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations:________________

2. Types of pain

☐ Dull ☐ Sharp ☐ Aching ☐ Cutting
☐Throbbing ☐ Burning ☐ Numbing ☐ Tingling ☐ Cramping
☐Spasm ☐ Stinging ☐ Shooting ☐ Pounding ☐Constricting

Other types of pain: ____________ ____________

3. Pain Frequency

☐Up to 1/4 of awake time ☐1/4 to 1/2 of time
☐1/2 to 3/4 of awake time ☐ Most all the time

4. Pain Intensity (How it affects your daily activites)

☐ Doesn't affect ☐ Somewhat affects
☐ Seriously affects ☐ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
☐ Head	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Shoulder	☐	☐	☐
☐ Arm	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Hip	☐	☐	☐
☐ Leg	☐	☐	☐
☐ Foot	☐	☐	☐

Other locations of radiation:____________

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
☐ In the A.M.	☐	☐	☐
☐ In the P.M.	☐	☐	☐
☐ Bending forward	☐	☐	☐
☐ Bending back	☐	☐	☐
☐ Bending left	☐	☐	☐
☐ Bending right	☐	☐	☐
☐ Twisting left	☐	☐	☐
☐ Twisting right	☐	☐	☐
☐ Coughing	☐	☐	☐
☐ Sneezing	☐	☐	☐
☐ Straining	☐	☐	☐
☐ Standing	☐	☐	☐
☐ Sitting	☐	☐	☐
☐ Lifting	☐	☐	☐
Other Actions:			
____________	☐	☐	☐
	☐	☐	☐

VIII. Eighth Current Symptom:
(Please check off the boxes below to describe your 8th symptom).

1. Check only one body location below

Location	L	R	B
☐Headaches	☐	☐	☐
☐Front of Head			
☐Top of Head			
☐Back of Head			
☐Jaw	☐	☐	☐
☐Eye	☐	☐	☐
☐Neck	☐	☐	☐
☐Upper Back	☐	☐	☐
☐Mid Back	☐	☐	☐
☐Low Back	☐	☐	☐
☐Chest	☐	☐	☐
☐Abdomen	☐	☐	☐
☐Ribs	☐	☐	☐
☐Buttocks	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Upper Arm	☐	☐	☐
☐Forearm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations:________________

2. Types of pain

☐ Dull ☐ Sharp ☐ Aching ☐ Cutting
☐Throbbing ☐ Burning ☐ Numbing ☐ Tingling ☐ Cramping
☐Spasm ☐ Stinging ☐ Shooting ☐ Pounding ☐Constricting

Other types of pain: ____________ ____________

3. Pain Frequency

☐Up to 1/4 of awake time ☐1/4 to 1/2 of time
☐1/2 to 3/4 of awake time ☐ Most all the time

4. Pain Intensity (How it affects your daily activites)

☐ Doesn't affect ☐ Somewhat affects
☐ Seriously affects ☐ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
☐ Head	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Shoulder	☐	☐	☐
☐ Arm	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Hip	☐	☐	☐
☐ Leg	☐	☐	☐
☐ Foot	☐	☐	☐

Other locations of radiation:____________

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
☐ In the A.M.	☐	☐	☐
☐ In the P.M.	☐	☐	☐
☐ Bending forward	☐	☐	☐
☐ Bending back	☐	☐	☐
☐ Bending left	☐	☐	☐
☐ Bending right	☐	☐	☐
☐ Twisting left	☐	☐	☐
☐ Twisting right	☐	☐	☐
☐ Coughing	☐	☐	☐
☐ Sneezing	☐	☐	☐
☐ Straining	☐	☐	☐
☐ Standing	☐	☐	☐
☐ Sitting	☐	☐	☐
☐ Lifting	☐	☐	☐
Other Actions:			
____________	☐	☐	☐
	☐	☐	☐

IX. Ninth Current Symptom:
(Please check off the boxes below to describe your 9th symptom).

1. Check only one body location below

Location	L	R	B
☐Headaches	☐	☐	☐
☐Front of Head			
☐Top of Head			
☐Back of Head			
☐Jaw	☐	☐	☐
☐Eye	☐	☐	☐
☐Neck	☐	☐	☐
☐Upper Back	☐	☐	☐
☐Mid Back	☐	☐	☐
☐Low Back	☐	☐	☐
☐Chest	☐	☐	☐
☐Abdomen	☐	☐	☐
☐Ribs	☐	☐	☐
☐Buttocks	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Upper Arm	☐	☐	☐
☐Forearm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations:________________

2. Types of pain

☐ Dull ☐ Sharp ☐ Aching ☐ Cutting
☐Throbbing ☐ Burning ☐ Numbing ☐ Tingling ☐ Cramping
☐Spasm ☐ Stinging ☐ Shooting ☐ Pounding ☐Constricting

Other types of pain: ____________ ____________

3. Pain Frequency

☐Up to 1/4 of awake time ☐1/4 to 1/2 of time
☐1/2 to 3/4 of awake time ☐ Most all the time

4. Pain Intensity (How it affects your daily activites)

☐ Doesn't affect ☐ Somewhat affects
☐ Seriously affects ☐ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
☐ Head	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Shoulder	☐	☐	☐
☐ Arm	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Hip	☐	☐	☐
☐ Leg	☐	☐	☐
☐ Foot	☐	☐	☐

Other locations of radiation:____________

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
☐ In the A.M.	☐	☐	☐
☐ In the P.M.	☐	☐	☐
☐ Bending forward	☐	☐	☐
☐ Bending back	☐	☐	☐
☐ Bending left	☐	☐	☐
☐ Bending right	☐	☐	☐
☐ Twisting left	☐	☐	☐
☐ Twisting right	☐	☐	☐
☐ Coughing	☐	☐	☐
☐ Sneezing	☐	☐	☐
☐ Straining	☐	☐	☐
☐ Standing	☐	☐	☐
☐ Sitting	☐	☐	☐
☐ Lifting	☐	☐	☐
Other Actions:			
____________	☐	☐	☐
	☐	☐	☐

Patient Sign & Date:______________________________ **Date:**____________________

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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.

My most recent prior similar symptoms (if applicable) occured.........___ ☐ months ago / ☐ years ago **Or on** Date: ____/____/____

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.

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

Patient Sign & Date:______________________________ **Date:**______________________________

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Cole Family Chiropractic
68 North High Street, Ste. E-106 New Albany, OH 43054
(614) 855-5454 (p) ~ (614) 283-5400 (f)

Patient Name: ____________________________ **Date:** _____________________

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Cole Family Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Women Only:

To the best of my knowledge I **am / am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation.
(Circle one above) *(Circle one above)*

Missed Appointments:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.

Consent to Evaluate and Treat a Minor:

I, ____________________________ being the parent or legal guardian of ____________________________, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: ____

Children: ____

Others: ____

No one: ____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: ____

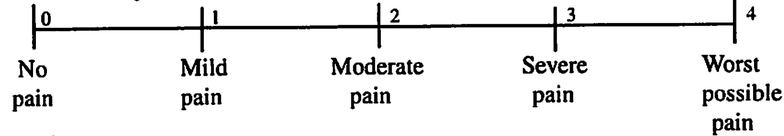
Signature: ________________________________ Date: ______________________

Functional Rating Index

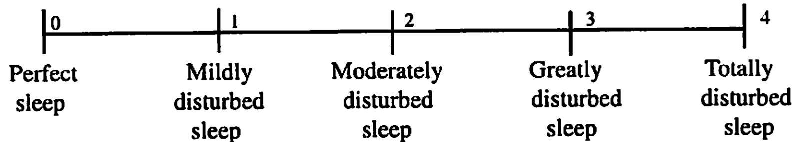
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

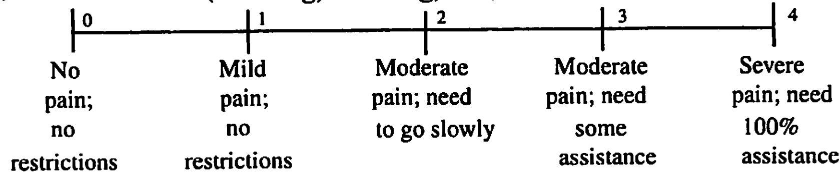
1. Pain Intensity



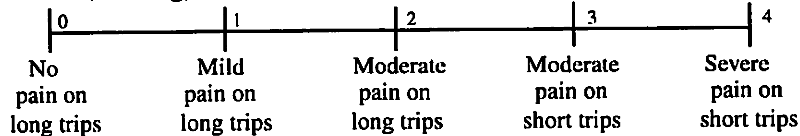
2. Sleeping



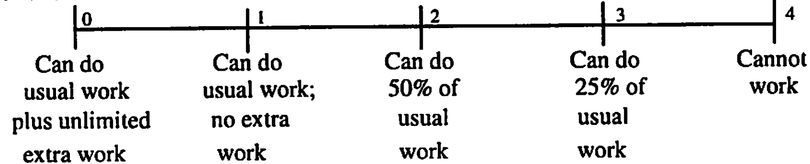
3. Personal Care (washing, dressing, etc.)



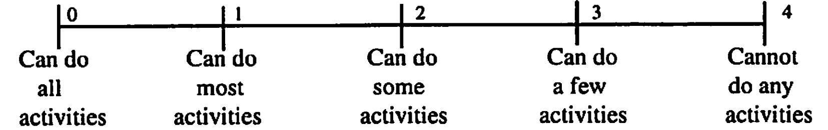
4. Travel (driving, etc.)



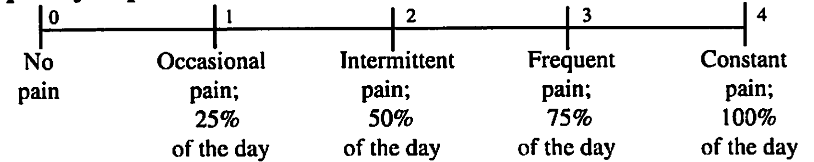
5. Work



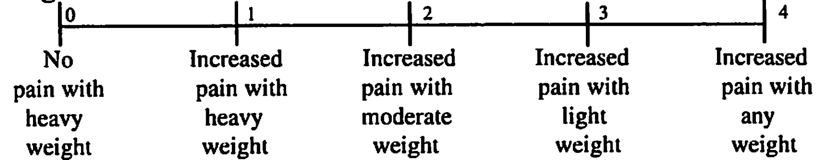
6. Recreation



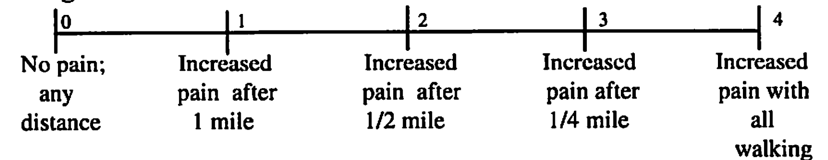
7. Frequency of pain



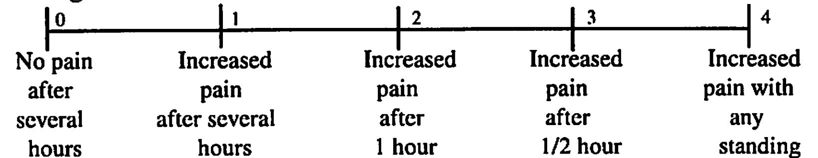
8. Lifting



9. Walking



10. Standing



Name ______________________________
PRINTED

Total Score __________

____
Signature

____
Date

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