## **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: ☐ Both ☐ Right ☐ Left 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.

## **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  | 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 ☐ Making a right turn ☐ Proceeding along Other  | ☐ Stopped in traffic ☐ Stopped at light ☐ Making a left turn ☐ Parking ☐ Slowing down ☐ Accelerating   |  |  |  |  |  |
| 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  | Visibility at time of accident ☐ Poor ☐ Fair ☐ Goo 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 Read-End Left Rear Right Rear   |  |  |  |  |  |  |
| 7. Body Position, etc.  |  |      |   |  |  |  |  |  |  |
| Did you see the accident comin Were you braced for the impact Did you have a seat belt on? Did you have a shoulder harner Did driver side air bags deploy?  8. Additional accident informat In the case of a motor vehicle acc  | Yes No  | What | t was the position of your len with top of head  Even it was the direction of your acing straight forward  Turbags deploy? Yes  No  | headrests? Yes \( \bar{\text{\tint{\text{\tint{\text{\ti}\text{\texitex{\text{\texi}\text{\text{\text{\text{\text{\text{\text{\text{\text{ |  |  |  |  |  |
| 9 During the conident   |  |      | 40.40   |  |  |  |  |  |  |
| 9. During the accident:  Did your body strike the inside of   | your vehicle? Yes \(\bar{\text{Ves}}\) No  |      | 10. After the accident:   | aht after and a few days following:  |  |  |  |  |  |
| Did your body strike the inside of your vehicle? Yes \( \text{Ves} \) No  If yes, describe:  Did you lose consciousness during the injury? Yes \( \text{Ves} \) No  If yes, for how long?  Your vehicle's estimated damage?  Damage to their vehicle: \( \text{Mild} \) Moderate \( \text{Totaled} \)  Did police show up at the scene? Yes \( \text{Ves} \) No  Was an accident report filled out? Yes \( \text{Ves} \) No |  |      | Check off your symptoms right after and a few days following:  Headache Dizziness Mid back pain Cold hands Low back pain Cold feet Low back pain Cold feet Neck stiffnes Confusion Nervousness Diarrhea Fainting Fatigue Loss of taste Depression Ringing in ears Tension Toe numbness Anxious Loss of smell Imitability Constipation Chest Pain Pain behind eyes Shortness of breath Sleeping problems Others: |  |  |  |  |  |  |
| 11. Emergency Room?   |  |      | 12. Treatment History:  |  |  |  |  |  |  |
| 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:   |  |      | Fill in any other doctor(s) seen prior to your first visit to this office  1. Dr First visit date:/ _/ Specialty: X-raysdone? Yes □ No  Types of treatments received: Currently treating? Yes □ No  Did treatments benefit you? Yes □ No  Last visit date:/ _/  2. Dr First visit date:/ _/  Types of treatments received: Currently treating: Yes □ No   |  |  |  |  |  |  |
| Treatments: Cervical Collar   | ☐ Ice Other:   | -    | Did treatments benefit you?  Last visit date:/  | First visit date://  |  |  |  |  |  |

| Description of Symptoms   | (Describe your symptoms in the sections below, in the   | e order of severity, if possible.)   |
|---|---|--|
| 1. Check only one body location below   | eck off the boxes below to describe your first sympto   | m. Describe only ONE symptom per Section Other types of pain:  |
| ☐Headaches L ☐ R ☐ B  |   | uttina   |
| □ Front of Head   | □Throbbing □ Burning □ Numbing □ 7  | ingling Cramping   |
| ☐ Top of Head☐ Back of Head☐  |   | ounding Constricting   |
| DJaw L D R D B  |   | 6. Actions affecting this pain   |
| □Eye L□ R□ B  | ☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time  | Brings On Aggravates Relieves  |
| □Neck L□ R□ B   | ☐ 1/2 to 3/4 of awake time ☐ Most all the time  | In the A.M.  |
| Upper Back L. R B   |   | In the P.M.  |
| Mid Back L R B  |   | Bending forward  |
| □LowBack L □ R □ B □ Chest L □ R □ B  |   | Bending left D D   |
| Abdomen L R B   |   | Bending right  |
| □Ribs L□ R□ B   |   | Twisting left  |
| □Buttocks L □ R □ B   |   | Twisting right   |
| ☐Shoulder L ☐ R ☐ B   | Neck 🗆 🗆  | Coughing   |
| UpperArm L R B  |   | Sneezing   |
| □Forearm L□ R□ B □Hand L□ R□ B  | Arm 0 0   | Standing   |
| OHip LO RO B  |   | Sitting  |
| □Leg L□ R□ B  | Hip O O O   |  |
| □Foot L□ R□ B   | D Foot  | OtherActions:  |
| Other locations :   | Other locations of radiation:   |  |
| II. Second Current Symptom:   | (Please check off the boxes below to describe you   | The same of the sa |
| Check only one body location below  | 2. Types of pain  | Other types of pain:   |
| ☐Headaches L ☐ R ☐ B ☐Front of Head   | Dull Sharp Aching O   | utting   |
| Top of Head   |   | ngling   |
| □ Back of Head  |   | ounding Constricting   |
| □Jaw L□ R□ B  |   | 6. Actions affecting this pain   |
| DEye LO RO B  | DAD to 214 of overlanding DA to at - 11 th - 15   | Brings On Aggravates Relieves  |
| □Neck L□ R□ B □UpperBack L□ R□ B  |   |  |
| UpperBack L R B   | 4. Pain intensity (How it affects your daily activites  | In the P.M. Bending forward Bending back Bending left Bending right Twisting left Coughing Straining Straining Stiting Stiting Stiting Stiting   |
| □LowBack L □ R □ B  | Doesn't affect Somewhat affects   | Bending back Bending left Bending left Bending right Twisting left Coughing Sneezing Straining Standing  |
| ☐Chest L☐ R☐ B  | Senously affects Prevents activities  | Bending left   |
| □Abdomen L □ R □ B  |   | Twisting left  |
| □Ribs L□ R□ B   |   | Twisting right   |
| □Buttocks L□ R□ B □Shoulder L□ R□ B   |   | Twisting right   |
| OUpperArm L O R O B   | Shoulder  | Sneezing   |
| □Forearm L□ R□ B  | Arm D D   | Straining  |
| □Hand L□ R□ B   |   | Standing   |
| □Hip L□ R□ B  |   | Sitting  |
| □Leg L□ R□ B □Foot L□ R□ B  |   | Other Actions:   |
| Other locations:  | Other locations of radiation:   |  |
|   |   | ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )  |
| III. Third Current Symptom:  1. Check only one body location below  | (Please check off the boxes below to describe your 3r  2. Types of pain                       | Other types of pain:   |
| ☐Headaches L ☐ R ☐ B I  |   | utting   |
| Front of Head   |   | ngling Cramping  |
| ☐ Top of Head<br>☐ Back of Head   | □ Spasm □ Stinging □ Shooting □ P   | ounding Constricting   |
| □Jaw L□ R□ BI   |   | 6. Actions affecting this pain   |
| □Eye L□ R□ BI   | ☐ 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 | Brings On Aggravates Relieves  |
| Neck L R B  |   | In the A.M.  |
| □UpperBack L□ R□ B I<br>□MidBack L□ R□ B I  | 4. Pain Intensity (How it affects your daily activites  | ☐ In the P.M. ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐  |
| OLowBack LO RO BI   |   | Bending back   |
| □Chest L□ R□ BI   | ☐ Seriously affects ☐ Prevents activities   | Bending left   |
|   |   | a Dending left   |
| □Abdomen L□ R□ B(   | 5. Does this pain radiate into other body parts'  | Bending right  |
| □ Abdomen L □ R □ B (<br>□ Ribs L □ R □ B (   | Left Right Both   | Bending right  |
| □ Abdomen         L         R         □         B         I         I         B         I         I         B         I | Left Right Both   | Bending right     Twisting left     Twisting right     Countries   |
| □ Abdomen         L         R         □         B         I         I         B         I         I         I         B         I | Left Right Both   | Bending right     Twisting left     Twisting right     Coughing     Speezing   |
| □ Abdomen         L         □         R         □         B         I         I         B         I         I         I         B         I | Left Right Both   | Bending forward  |
| □ Abdomen       L □       R □       B □         □ Ribs       L □       R □       B □         □ Buttocks       L □       R □       B □         □ Shoulder       L □       R □       B □         □ UpperArm       L □       R □       B □         □ Forearm       L □       R □       B □         □ Hand       L □       R □       B □  | Left Right Both   | Bending right  |
| □ Abdomen       L □       R □       B □         □ Ribs       L □       R □       B □         □ Buttocks       L □       R □       B □         □ Shoulder       L □       R □       B □         □ UpperArm       L □       R □       B □         □ Forearm       L □       R □       B □         □ Hand       L □       R □       B □         □ Hip       L □       R □       B □  | Left Right Both   | Straining  |
| □ Abdomen       L □       R □       B □         □ Ribs       L □       R □       B □         □ Buttocks       L □       R □       B □         □ Shoulder       L □       R □       B □         □ UpperArm       L □       R □       B □         □ Forearm       L □       R □       B □         □ Hand       L □       R □       B □  | Left Right Both   | Bending right Twisting left Coughing Straining Straining Standing Standing Stifting Cliffing Cher Actions:   |

| Description of Symptoms (Describe your symptoms in the sections below, in the order of severity, if possible.) |                         |            |           |                 |               |  |                |       |                                |              |               |               |
|--|-------------------------|------------|-----------|-----------------|---------------|--|----------------|-------|--------------------------------|--------------|---------------|---------------|
| IV. Fourth Syr   | mptom:                  | (Ple       | ase check |                 |               |  |                |       | Describe only ONE              |              |               |               |
| 1. Check only o  |                         | location l | below     | 2. Types of     |               | 1542   |                |       |                                |              |               | of pain:      |
| Headaches  | L O                     | R 🔲        | В         | Dull Dull       | ☐ Sharr       | □ Act  | nina 🗆         | Cu    | tting                          |              |               |               |
|  | Front of Heal           |            |           | Throbbing       |               | ng. Nu   |                |       | gling                          |              |               |               |
|  | op of Hea<br>Back of He |            |           | Spasm           | ☐ Stingi      | ng She   |                |       | unding Constricting            | 1            |               |               |
| Quaw   | L 🔲                     | R 🔲        | п.П       | 3. Pain Frequ   |               | 3  | -              |       | 6. Actions affectin            |              | pain          |               |
| Eye  | 10                      | RO         | В         | □ Up to 1/4 of  |               | □1/4 to  | 1/2 of tim     |       |                                | _            | -             | s Relieves    |
| Neck   | 10                      | R          | вО        | □1/2 to 3/4 of  |               |  |                |       | ☐ In the A.M.                  |              | - Garage      |               |
| Upper Back   | 10                      | R          | в         |                 |               |  |                |       | In the P.M.                    |              |               |               |
| Mid Back   | io                      | R          | вО        | 4. Pain Intens  | ity (How it   | affects you  | r daily activ  | ites  | Bending forward                |              |               |               |
| □LowBack   | LO                      | R 🗖        | в         | Doesn't affe    | ect 🗆         | Somewha  |                | 1     | Bending back                   |              |               |               |
| Chest  | LO                      | R 🔾        | вО        | Seriously at    | ffects        | Prevents   | activities     |       | ☐ Bending left                 | 000000000    | 00000000000   | 0000000000000 |
| Abdomen  | L                       | R          | В         | 5. Does this p  | de endiate    | into other t   | -4             | _     | Bending right                  |              |               |               |
| Ribs   | L 🔲                     | R 🔲        | В         | 5. Does this p  | Left          | Right  | Both           |       | ☐ Twisting left                |              |               |               |
| Buttocks   | L 🛄                     | R 🔲        | В         | Head            |               |  |                |       | ☐ Twisting right               |              |               |               |
| Shoulder   | L                       | R 🚨        | В         | Neck            |               |  |                | 1     | ☐ Coughing                     |              |               |               |
| □ Upper Arm  |                         | R 🔲        | В         | Shoulder        |               |  |                | 1     | Sneezing                       | _            | 4             | <u>u</u>      |
| Forearm  | L 🛄                     | R 🛄        | В         | □Arm            |               |  |                |       | Straining                      | H            | 4             | 7             |
| Hand   | L 🛄                     | R 🛄        | В         | ☐ Hand          |               |  |                |       | ☐ Standing                     | H            | H             | H             |
| Hip  | LO                      | R 🔲        | В         | ☐ Hip           |               |  |                |       | ☐ Sitting ☐ Lifting            |              | 2             | 3             |
| Leg  |                         | R          | В         | Leg             |               |  |                |       | Other Actions:                 | _            | _             | _             |
| Foot   |                         | R 🔲        | В         | ☐ Foot          |               |  |                | - 1   | Other Actions.                 |              |               |               |
| Other locations  | 5:                      |            |           | Other location  | ns of radi    | ation:   |                | _     |                                | ă            | ŏ             | ŏ             |
| V. Fifth Curre   | nt Symp                 | tom:       |           | (Please che     | ck off the b  | oxes belo  | w to descri    | ibe v | our 5th symptom).              | -            |               |               |
| 1. Check only  | one body                |            | below     | 2. Types of     |               |  |                | ,     |                                | Othe         | r types       | of pain:      |
| Headaches  | L                       | R 🔲        | В         | □ Dull          | ☐ Shart       | □ Acl  | nina [         | Cu    | tting                          |              |               |               |
|  | Front of He             |            |           | Throbbing       |               |  |                |       | gling                          |              |               |               |
|  | Top of Hea              |            |           | Spasm           | Stingi        |  |                |       | unding Constricting            | ,            |               |               |
| □ Jaw  | Back of He              | R 🔲        | в□        | 3. Pain Frequ   |               |  | Journey W      |       | 6. Actions affectin            |              | pain          |               |
| Eye  | 1 0                     | RO         | В         | □ Up to 1/4 of  |               | □ 1/4 to   | 1/2 of tim     | e     |                                | _            | -             | Relieves      |
| Neck   | 10                      | R          | вП        | 1/2 to 3/4 of   | fawake tim    | e Most   | all the time   |       | In the A.M.                    |              |               |               |
| Upper Back   | 10                      | R          | В         |                 |               |  |                |       | ☐ In the P.M.                  |              |               |               |
| ☐ Mid Back   | LO                      | R 🔾        | вО        | 4. Pain Intens  |               |  |                | rites | Bending forward                |              | 000000000000  | 00000000000   |
| LowBack  | LO                      | R 🖸        | В         | Doesn't aff     |               | Somewha  |                |       | Bending back                   |              |               |               |
| Chest  | ī o                     | R 🔲        | В         | Seriously at    | ffects        | Prevents   | activities     |       | Bending left                   |              |               | ü             |
| Abdomen  | L 🚨                     | R 🔾        | в         | 5. Does this pa | ain radiate   | into other b   | ody parts?     |       | Bending right                  |              | <u>u</u>      | Ä             |
| Ribs   | L                       | R 🔲        | В         |                 | Left          | Right  | Both           |       | Twisting left                  | 000          | H             | <u> </u>      |
| Buttocks   | L                       | R 🔲        | В         | ☐ Head          |               |  |                |       | Twisting right                 | 7            | 7             | =             |
| Shoulder   | L                       | R 🔲        | В         | ☐ Neck          |               |  |                |       | ☐ Coughing☐ Sneezing           |              | 7             |               |
| ☐ Upper Arm  | L                       | R 🔲        | В         | ☐ Shoulder      |               |  |                |       | ☐ Straining                    |              | H             | H             |
| Forearm  | L                       | R 🛄        | В         | □Arm            |               |  |                |       | ☐ Standing                     | ō            | ō             | ō             |
| Hand   | L                       | R 🛄        | В         | ☐ Hand          |               |  |                |       | Sitting                        | ō            | ŏ             | ō             |
| Hip  | L 🖸                     | R 🔲        | В         | ☐ Hip           | 000           |  | 000            |       | Lifting                        | 000          | ō             | ō             |
| □ Leg<br>□ Foot  | L 0                     | R 🔲        | ВО        | Leg             | 3             |  |                |       | Other Actions:                 | 72           | -             |               |
| Other locations  |                         | RU         | В         | Other locatio   |               |  | <b>U</b>       |       |                                |              |               |               |
|  | -                       |            |           |                 |               |  |                | _     |                                |              |               |               |
| VI. Sixth Curr   | ent Sym                 | ptom:      | (F        | Please check of |               | s below to   | describe y     | our   | 6th symptom).                  |              |               |               |
| 1. Check only o  | L 🔲                     | R 🔲        | B 🔲       | 2. Types of     | oain          |  |                |       |                                | Othe         | r types       | of pain:      |
|  | ront of He              |            | B 🛥       | ☐ Dull          | ☐ Sharp       |  |                | Cu    |                                |              |               |               |
|  | op of Head              |            |           | Throbbing       | Burnir        |  |                |       | gling                          |              |               |               |
| □B   | ack of Hea              |            |           | Spasm           | Stingi        | ng 🔲 Sho   | ooting L       | Pol   | unding Constricting            |              |               |               |
| □Jaw   | L 📮                     | R 🔲        | в         | 3. Pain Frequ   |               | D444 +   | 410            | - 1   | 6. Actions affecting           | g this       | pain          |               |
| Eye  | L 🛄                     | R 🚨        | В         | Up to 1/4 of    |               |  |                |       |                                |              | gravates      |               |
| Neck   | L 🛄                     | R 🚨        | В         | □ 1/2 to 3/4 of | awake tim     | e u Most   | all the time   |       | In the A.M.                    |              |               |               |
| Upper Back   | L 🖸                     | R          | В         | 4. Pain Intens  | ity (How it   | offacte vous   | r daily active | itoo  | In the P.M.                    |              |               |               |
| Mid Back   | L 🖸                     | R          | В         | Doesn't affe    |               | Somewha  |                | nes   | Bending forward                |              |               | <u> </u>      |
| LowBack  | L 🖸                     | R          | В         | Seriously af    |               | Prevents   |                |       | Bending back                   |              | =             | -             |
| ☐ Chest<br>☐ Abdomen   |                         | R 🔲        | B 🔲       |                 |               |  |                |       | ☐ Bending left ☐ Bending right | H            | H             | 8             |
| ☐ Ribs   | 10                      | RO         | В         | 5. Does this pa |               |  |                |       | ☐ Twisting left                | ä            | H             | ă l           |
| Buttocks   | 10                      | R          | В         | ☐ Head          | Left          | Right  | Both           |       | ☐ Twisting right               | ŏ            | Ħ             | n l           |
| Shoulder   | נֿם                     | RO         | В         | □ Neck          | H             |  |                | 1     | Coughing                       | ō            | ă             | - i           |
| Upper Arm  | 10                      | RO         | В         | Shoulder        |               | ä  | ŏ              |       | ☐ Sneezing                     |              |               | <u> </u>      |
| Forearm  | LO                      | R          | В         | Arm             | ā             | ă  |                |       | ☐ Straining                    |              |               | <u> </u>      |
|  |                         | R 🔲        | вО        | Hand            | ă             | 100  | 00000          |       | ☐ Standing                     | 000000000000 |               |               |
| Hand   | L                       |            |           |                 | Total Control | The state of the s | -              | - 1   |                                |              | _             |               |
| ☐Hand<br>☐Hip  | LO                      | R 🗆        | В         |                 |               |  |                |       | ☐ Sitting                      |              |               | <b>u</b>      |
| □Hip<br>□Leg   | r 0                     | R □<br>R □ | B 🔲       | ☐ Hip<br>☐ Leg  |               |  |                |       | ☐ Sitting ☐ Lifting            |              | 0000000000000 | 00000000000   |
| □Hip   | L 000                   | R 🔲        | В         | ☐ Hip           |               |  | 000            |       |                                | 00 0         | 00 0          | 0             |

**Description of Symptoms** 

| 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  Headaches L R R B B   | 2. Types of pain   | Other types of pain:   |  |  |  |  |  |
| ☐Headaches L ☐ R ☐ B ☐   | □ Dull □ Sharp □ Aching □ C  | utting   |  |  |  |  |  |
| ☐ Top of Head  | ☐Throbbing ☐ Burning ☐ Numbing ☐ Ti  | ngling   |  |  |  |  |  |
| ☐ Back of Head   | □Spasm □ Stinging □ Shooting □ Po  | ounding Constricting   |  |  |  |  |  |
| DJaw L R B B   | 3. Pain Frequency  | 6. Actions affecting this pain   |  |  |  |  |  |
| □Eye L□ R□ B□  | ☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time   | Brings On Aggravates Relieves  |  |  |  |  |  |
| □Neck L□ R□ B□   | ☐ 1/2 to 3/4 of awake time ☐ Most all the time   | ☐ In the A.M. ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐  |  |  |  |  |  |
| Upper Back L R B   |  | In the P.M.  |  |  |  |  |  |
| ☐Mid Back L☐ R☐ B☐   | 4. Pain Intensity (How it affects your daily activites   | Bending forward  |  |  |  |  |  |
| OLowBack LORD BO   | ☐ Doesn't affect ☐ Somewhat affects ☐ Prevents activities  | Bending back   |  |  |  |  |  |
| ☐Chest L☐ R☐ B☐ ☐Abdomen L☐ R☐ B☐  |  | Bending right D D  |  |  |  |  |  |
| □ Abdomen L □ R □ B □ □ Ribs L □ R □ B □   | 5. Does this pain radiate into other body parts?   | ☐ Twisting left ☐ ☐ ☐  |  |  |  |  |  |
| Buttocks L R B B   | Left Right Both  | ☐ Twisting right ☐ ☐ ☐   |  |  |  |  |  |
| □Shoulder L□ R□ B□   | O Neck   | ☐ Coughing ☐ ☐ ☐   |  |  |  |  |  |
| Upper Arm L R B  |  | Bending forward  Bending back  Bending left  Bending right  Twisting left  Coughing  Sneezing  Straining  Standing  Stifting  Slifting   |  |  |  |  |  |
| □Forearm L□ R□ B□  | □ Shoulder □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □   | ☐ Straining ☐ ☐ ☐  |  |  |  |  |  |
| □Hand L□ R□ B□   | ☐ Hand ☐ ☐ ☐   | Standing   |  |  |  |  |  |
| □Hip L□ R□ B□  | □ Hand □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □   | Sitting  |  |  |  |  |  |
| OLeg LOROBO  | Leg  | Other Actions:   |  |  |  |  |  |
| Foot L R B   | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1  |  |  |  |  |  |  |
| Other locations :  | Other locations of radiation:  |  |  |  |  |  |  |
| VIII. Eighth Current Symptom:  | (Please check off the boxes below to describe  | your 8th symptom).   |  |  |  |  |  |
| 1. Check only one body location below  | 2. Types of pain   | Other types of pain:   |  |  |  |  |  |
| ☐Headaches L ☐ R ☐ B ☐   | □ Dull □ Sharp □ Aching □ Co   | utting   |  |  |  |  |  |
| ☐ Front of Head  | ☐Throbbing ☐ Burning ☐ Numbing ☐ Ti  | ngling   |  |  |  |  |  |
| ☐ Top of Head<br>☐ Back of Head  |  | ounding Constricting   |  |  |  |  |  |
| QJaw L Q R Q B Q   | 3. Pain Frequency  | 6. Actions affecting this pain   |  |  |  |  |  |
| OEye LO RO BO  | Up to 1/4 of awake time 1/4 to 1/2 of time   | Brings On Aggravates Relieves  |  |  |  |  |  |
| Neck LO RO BO  | ☐ 1/2 to 3/4 of awake time ☐ Most all the time   | ☐ In the A.M. ☐ ☐ ☐  |  |  |  |  |  |
| □UpperBack L□ R□ B□  | 15111  | ☐ In the P.M. ☐ ☐  |  |  |  |  |  |
| ☐Mid Back L ☐ R ☐ B ☐  | 4. Pain Intensity (How it affects your daily activites  Doesn't affect  Somewhat affects   | Bending forward Bending back Bending left Bending left Bending right Twisting left Coughing Straining Straining Standing Stiting Lifting |  |  |  |  |  |
| □LowBack L □ R □ B □   | ☐ Seriously affects ☐ Prevents activities  | Bending left D D   |  |  |  |  |  |
| Chest L R B  |  | ☐ Bending right ☐ ☐ ☐  |  |  |  |  |  |
| Abdomen L R B B  | 5. Does this pain radiate into other body parts?   | Bending right  |  |  |  |  |  |
| ☐Ribs L☐ R☐ B☐ ☐Buttocks L☐ R☐ B☐  | Left Right Both  | Twisting right   |  |  |  |  |  |
| Shoulder L R B B   | Head   | ☐ Coughing ☐ ☐ ☐   |  |  |  |  |  |
| OUpperArm LO RO BO   |  | ☐ Sneezing ☐ ☐ ☐   |  |  |  |  |  |
| □Forearm L □ R □ B □   | □ Shoulder □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □   | ☐ Straining ☐ ☐ ☐  |  |  |  |  |  |
| □Hand L□ R□ B□   | ☐ Arm ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐  | Standing   |  |  |  |  |  |
| □Hip L□ R□ B□  | ☐ Hip ☐ ☐  |  |  |  |  |  |  |
| Leg L R B  | Leg C C  | ☐ Lifting ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐  |  |  |  |  |  |
| □Foot L□ R□ B□   |  | Other Actions.   |  |  |  |  |  |
| Other locations :  | Other locations of radiation:  |  |  |  |  |  |  |
| IX. Ninth Current Symptom:   | Please check off the boxes below to describe your  | 9th symptom).  |  |  |  |  |  |
| Check only one body location below   | 2. Types of pain   | Other types of pain:   |  |  |  |  |  |
| ☐Headaches L ☐ R ☐ B ☐   | □ Dull □ Sharp □ Aching □ Cu   |  |  |  |  |  |  |
| ☐ Front of Head  | ☐Throbbing ☐ Burning ☐ Numbing ☐ Tir   |  |  |  |  |  |  |
| ☐ Top of Head  |  | unding Constricting  |  |  |  |  |  |
| Back of Head  Jaw  L D R D B D   | 3. Pain Frequency  | 6. Actions affecting this pain   |  |  |  |  |  |
| DEye LO RO BO  | ☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time   | Brings On Aggravates Relieves  |  |  |  |  |  |
| ONeck LO RO BO   | ☐ 1/2 to 3/4 of awake time ☐ Most all the time   | ☐ In the A.M. ☐ ☐ ☐  |  |  |  |  |  |
| Upper Back L R R B   |  | ☐ In the P.M. ☐ ☐ ☐  |  |  |  |  |  |
| ☐Mid Back L ☐ R ☐ B ☐  | 4. Pain Intensity (How it affects your daily activites)  | ☐ Bending forward ☐ ☐ ☐  |  |  |  |  |  |
| □LowBack L □ R □ B □   | ☐ Doesn't affect ☐ Somewhat affects  | Bending back   |  |  |  |  |  |
| Chest L R B  | ☐ Seriously affects ☐ Prevents activities  | ☐ Bending left ☐ ☐ ☐   |  |  |  |  |  |
| Abdomen L R B B  | 5. Does this pain radiate into other body parts?   | Bending right  |  |  |  |  |  |
| □Ribs L□ R□ B□<br>□Buttocks L□ R□ B□   | Left Right Both  | ☐ Twisting left ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐  |  |  |  |  |  |
| ☐Buttocks L ☐ R ☐ B ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐  | ☐ Head ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐   | Coughing C   |  |  |  |  |  |
| OUpperArm LO RO BO   |  | Sneezing   |  |  |  |  |  |
| □Forearm L □ R □ B □   |  | ☐ Straining ☐ ☐ ☐  |  |  |  |  |  |
| □Hand L□ R□ B□   | □ Arm □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □  | ☐ Standing ☐ ☐ ☐   |  |  |  |  |  |
| □Hip L□ R□ B□  | ☐ Hip ☐ ☐  | ☐ Sitting ☐ ☐ ☐  |  |  |  |  |  |
| □Leg L□ R□ B□  | Leq 🔲 🖸  | Lifting .  |  |  |  |  |  |
| Office I Descriptions:   | The state of the s | OtherActions:  |  |  |  |  |  |
|  | Other locations of radiation:  |  |  |  |  |  |  |

**Description of Symptoms** 

## **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 Brushing teeth ..... Putting on shoes ..... Preparing meals ..... Taking out trash ...

Making bed ....... Eating ......... Doing laundry .....

Putting on shift Putting on parts Cleaning dishes Going to toilet Bathing ..... Drying hair ..... Showering ..... Combing hair ..... 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 ...... Reaching ...... Bending left ...... Twisting right ...... Leaning left ...... Bending forward ... Bending right ...... Leaning forward .... Leaning right ...... Standing for long periods ...... Kneeling 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 .... Pushing things while standing ... Exercising upper body ...... Exercising lower body ...... Carrying brief case ....... Climbing stairs ...... Pulling things while seated ......

Carrying large purse ....... Climbing inclines ...... Pulling things while standing .... Exercisingarms ..... Exercising legs ..... Difficulties with Social and Recreational Activities Bowling ....... Jogging ...... Swimming ...... Ice Skating ...... Competitive Sports . Dating ........ Golfing ...... Hobbies ...... Dining out ...... Difficulties with Travelling 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** Has your History Contributed to your Current Symptoms? I have NOT had prior symptoms similar to my current complaints. My history HAS contributed to my current symptoms. My current complaints DID exist before, but have not been bothering me. My history HAS NOT contributed to my current symptoms. My current complaints ALREADY existed and were worsened. I'm NOT SURE if my history has contributed to my current symptoms. My most recent prior similar symptoms (if applicable) occured...... months ago / years ago Or on Date: Write in below any other Prior Symptom History, not covered above: