

Accident History

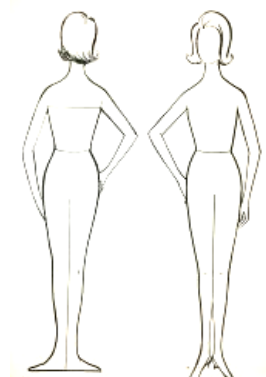
___ Job ___ Auto ___ Other 1) _____ Date: _____
___ Job ___ Auto ___ Other 2) _____ Date: _____
___ Job ___ Auto ___ Other 3) _____ Date: _____

Have you ever had a metal implant? Yes ___ No ___ Ever been gun shot? Yes ___ No ___

Describe Major Complaints

Rate your symptoms 1-10, with 10 being the worst pain you could imagine.

1) _____
2) _____
3) _____
4) _____



Symptoms are worse in: Morning ___ Afternoon ___ Night ___
When and what was the cause?

Symptoms developed from: Job Related ___ Auto Accident ___ Accident ___ Illness ___
Unknown cause ___ Gradual onset ___ Other ___ Date Occurred: _____
Symptoms have persisted for #: Hours ___ Day(s) ___ Week(s) ___ Month(s) ___ Years(s) ___
Symptoms: Come and go ___ Are Constant ___
Have you ever had this before? No ___ Yes ___ If yes, when? _____
If you were to guess, what do you think is causing your complaints? _____
Name and location of Doctors previously seen for present condition(s)? _____

Are you allergic to any medications? Yes ___ No ___ What kind? _____
Are you taking any medications? Yes ___ No ___ What kind? _____
Are you pregnant? Yes ___ No ___ Date of last menstrual period: _____

Please check the following activities that aggravate your condition:

Bending ___ Reaching ___ Straining at stool ___ Coughing ___ Turning Head ___
Lifting ___ Sneezing ___ Walking ___ Lying Down ___ Standing ___ Sitting ___

Please check the following activities that relieve your condition:

Bending ___ Sitting ___ Lifting ___ Standing ___ Lying Down ___ Reaching ___
Walking ___ Turning Head ___

Please check any additional symptoms you may be experiencing:

___ Blurred vision ___ Diarrhea ___ Insomnia ___ Pins/Needles
___ Buzzing in ears ___ Dizziness ___ Light sensitive ___ Low resistance to colds
___ Cold feet/hands ___ Face Flushed ___ Loss of balance ___ Shortness of breath
___ Cold sweats ___ Fainting ___ Loss of taste ___ Concentration loss/confusion
___ Stiff neck ___ Fatigue ___ Muscle jerking ___ Indigestion
___ Headaches ___ Fever ___ Constipation ___ Head seems too heavy
___ Numbness in fingers ___ Numbness in toe ___ Ringing in ears ___ Depression/weeping spells

Patient Signature: _____ **Date:** _____