PATIENT INJURY/MEDICAL HISTORY FORM

Name _____ Date _____

Social Security Number: _____

Patient Height: ___'___" Patient Weight: _____lbs. Patient is: Right handed or Left Handed

Date of Collision: _____ Vehicles Involved: _____

Your Vehicle - Year _____ Make _____ Model _____ Other Vehicle Year _____ Make _____ Model _____

Accident Type: [ ] Rear ended [ ] Head-on [ ] Broad-sided Your Speed _____ Other Vehicle Speed _____

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

Describe Accident: _____

_____

_____

Specifics of Accident (Mark each that applies to the accident):

Job or Work Related injury ( ) Yes

Your were the [ ] Driver [ ] Passenger

Sitting [ ] Front seat [ ] Back seat

[ ] Seat belted [ ] No seatbelt

Impending Collision [ ] Aware [ ] Unaware

[ ] Braced [ ] Not braced

Head Did [ ] Strike Object [ ] Not strike Object

[ ] Broken Glass

Did you experience [ ] Shock [ ] Loss of Consciousness

[ ] Flash of Light Seen Upon Impact

Air bag Deployed [ ]

State your Emotions and Physical State *Immediately Following* the accident:

_____

_____

_____

The Road was:

[ ] Dry
[ ] Wet
[ ] Icy
[ ] Snowy

The Weather Conditions were:

[ ] Sunny [ ] Light rain
[ ] Cloudy [ ] Heavy rain
[ ] Foggy [ ] Snowing

Time of Day: [ ] Dawn [ ] Day [ ] Dusk [ ] Night [ ] Unknown

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

Other Doctors Seen:

[ ] Orthopedist [ ] Neurologist
[ ] Psychiatrist [ ] Physical Therapist
[ ] Massage Therapist [ ] Chiropractor

State your Emotions & Physical State *after the first few days* :

_____

_____

_____

Symptomatology (Pain Characteristics for Major Area of Complaint):

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 is concerned: i.e. comes & goes, constant, etc.)_____

PATIENT INJURY/MEDICAL HISTORY FORM

Name _____ Date _____

Daily Activities

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

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

What are the worst times of 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	Increased	Duration
Sitting	[ ]	[ ]	[ ]	_____
Walking	[ ]	[ ]	[ ]	_____
Standing	[ ]	[ ]	[ ]	_____
Lying Down	[ ]	[ ]	[ ]	_____
Looking up	[ ]	[ ]	[ ]	_____
Looking Down	[ ]	[ ]	[ ]	_____
Lifting	[ ]	[ ]	[ ]	_____

What do you do to relieve the pain?

Pain Rating

On a scale of 1- 10 rate your pain.

No Pain Severe Pain

0 1 2 3 4 5 6 7 8 9 10

Describe the overall severity of the pain

[ ] Mild Nuisance
[ ] Mild to moderate but can live with it
[ ] Moderate, having trouble coping 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

Please mark each that apply to your Daily Activities

[ ] Stays at home most of the time due to the problem.
[ ] Changes position frequently to try and get comfortable.
[ ] Walks more slowly than usual because of the problem.
[ ] Does not do jobs around the house because of the problem.
[ ] Has to use handrails to get up stairs, etc.
[ ] Has to lie down and rest frequently due to the problem.
[ ] Has to hold onto something to sit or stand from a chair.
[ ] Has to get other people to do things for you.
[ ] Has difficulty getting dressed due to the problem.
[ ] Can only stand for short periods due to the problem.
[ ] Has difficulty bending or kneeling due to the problem.
[ ] Has difficulty turning over in bed due to the problem.
[ ] Has a loss of appetite due to the problem.
[ ] Can only walk short distances because of the problem.
[ ] Has difficulty sleeping because of the problem.
[ ] Has to get dressed with someone's help.
[ ] Has to sit most of the day because of the problem.
[ ] Has more irritable because of the problem.
[ ] Has difficulty climbing stairs.
[ ] Stays 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 cannot be performed now to the same extent as before?

_____

_____

_____

_____

_____

_____

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

PATIENT INJURY/MEDICAL HISTORY FORM

Name _____ Date _____

Social History

[ ] Single
[ ] Married
[ ] Divorced
Number of Children: _____

[ ] Smoker
[ ] Non-Smoker
[ ] Drinks Alcohol
[ ] Does not drink Alcohol
[ ] Takes Drugs
[ ] Does not take Drugs

List your Hobbies & Exercise Activities

_____

_____

_____

Occupational History

Your Employer _____

Job Title _____

What is your current job satisfaction:

[ ] Very Satisfied
[ ] Satisfied
[ ] Dissatisfied
[ ] Very Dissatisfied

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

Your highest level of education attained?

_____

Medical History

List the Physicians and other practitioners your have seen for your problem.

_____
_____
_____
_____

List the Medications you are currently taking:

_____
_____
_____
_____

List the treatments you have had for your problem.

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

List the types of Diagnostic Testing that has been performed for this problem.

[ ] X-rays
[ ] CT Scan
[ ] Myelogram
[ ] MRI Scan
[ ] Discogram
[ ] Bone Scan
[ ] EMG

List Past Surgeries: [ ] None

_____
_____
_____

List previous back, neck and musculoskeletal problems you have had.

_____
_____
_____
_____
_____
_____
_____

List Past Hospitalizations: [ ] None

_____
_____
_____

PATIENT INJURY/MEDICAL HISTORY FORM

Name _____ Date _____

Medical History

Mark if you have had any of 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
[ ] Lumps in neck, armpit or groin
[ ] Chest pain or tightness
[ ] Persistent or unusual cough
[ ] Trouble breathing with exercise
[ ] Trouble breathing lying flat
[ ] Coughing up blood
[ ] 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
[ ] Morning stiffness
[ ] Persistent eye redness
[ ] Muscle tenderness
[ ] Dry eyes or mouth
[ ] Skin rashes
[ ] Joint pain or swelling

Females – Mark if have the following:

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

Do you have any current problem with:

[ ] anxiety
[ ] depression
[ ] irritability

Do you have a home exercise program that you follow on a regular basis?

[ ] Yes [ ] No

Patient Basic Information

Personal Information:

Last Name:	First Name:	Middle Initial:
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.:

1. **Description of Accident/Injury/Onset**
   Enter a full description of the accident, injury or onset in the space below.

2. **During and after accident details**
   Enter the details of your condition during and after the accident/onset.

Patient Name: _____ **Date:** _____

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

V. **Current Symptom**: (Please check off the boxes below to describe your symptom. Describe only ONE symptom per section.

1. Check only one body location below

	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 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 forwrd.	❑	❑	❑
❑Bending back	❑	❑	❑
❑Bending left	❑	❑	❑
❑Bending right	❑	❑	❑
❑Twisting left	❑	❑	❑
❑Twisting right	❑	❑	❑
❑Coughing	❑	❑	❑
❑Sneezing	❑	❑	❑
❑Straining	❑	❑	❑
❑Standing	❑	❑	❑
❑Sitting	❑	❑	❑
❑Lifting	❑	❑	❑
Other Actions:			
_____	❑	❑	❑
_____	❑	❑	❑

Date of Onset: _____

How Often: Constant Comes&Goes Upon Mvmt. Time Each Day:

Radiates: No / Yes - Where:

Ever Before: No / Yes - When

Better/ Worse: B: W:

Other Treatment

Notes:

VI. **Current Symptom**: (Please check off the boxes below to describe your symptom. Describe only ONE symptom per section.

1. Check only one body location below

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❑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: _____

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❑Arm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations of radiation: _____

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❑In the P.M.	❑	❑	❑
❑Bending forwrd.	❑	❑	❑
❑Bending back	❑	❑	❑
❑Bending left	❑	❑	❑
❑Bending right	❑	❑	❑
❑Twisting left	❑	❑	❑
❑Twisting right	❑	❑	❑
❑Coughing	❑	❑	❑
❑Sneezing	❑	❑	❑
❑Straining	❑	❑	❑
❑Standing	❑	❑	❑
❑Sitting	❑	❑	❑
❑Lifting	❑	❑	❑
Other Actions:			
_____	❑	❑	❑
_____	❑	❑	❑

Date of Onset: _____

How Often: Constant Comes&Goes Upon Mvmt. Time Each Day:

Radiates: No / Yes - Where:

Ever Before: No / Yes - When

Better/ Worse: B: W:

Other Treatment

Notes: