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**Physical Medicine & Rehabilitation by Joe**

**6401 Douglas Avenue, Unit 12**

**Urbandale IA 50322**

**515-270-7050; website: fmmar.com**

## WELCOME TO OUR PRACTICE

I am constantly striving to offer the most thorough care. Please be as complete as possible finishing this questionnaire to help provide an efficient and comprehensive evaluation and treatment. This questionnaire is confidential and will be made part of your medical record.

**Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of person completing form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name: Age: \_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone#: \_\_\_Work Phone#: \_\_\_\_\_ Cell Phone#: \_\_\_\_\_**

**Which number should we use to contact you? (circle)**

**Referring Physician:\_\_ \_\_\_\_\_\_\_**

**Referring Physician Address: Phone: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Physician (PCP) (if different than referring physician):**

**PCP Address: Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**State your main problem:**

**What do you expect your visit to accomplish with this visit?**

**When did your problem begin?**

**How did your problem start? (If injury, please describe):**

**Where is your pain located?**

**If your pain spreads to other areas, please describe where:**

**What does your pain feel like?**

€ Burning € Sharp € Pins/Needles € Numbness € Electric-Like

€ Throbbing € Pressure € Cramping € Dull/Aching € Other

**How often do you have this pain?**

€ All the time (constantly) € Most of the Time € Occasionally € Rarely

**PAIN DIAGRAM:**

If “10” is the worst pain or discomfort you ever had and “0” is no pain or discomfort, how would you rate your pain or discomfort today? (Circle number below)

l l

0 1 2 3 4 5 6 7 8 9 10

Mark the areas on your body where you feel the sensations described below. Use the symbol shown. Include all affected areas that are active presently or at times. Please draw in face.

|  |  |  |  |
| --- | --- | --- | --- |
| **Pins and Needles**  **o o o o** | **Aching**  **⏶⏶⏶** | **Burning**  **X X X** | **Weakness**  **# # #** |
| **Numbness**  **= = =** | **Stabbing**  **/ / /** | **Other**  **• • •** |

Back

Front

Right

Left

|  |  |
| --- | --- |
| Left  Right | Left  Right |

**Relieving and aggravating factors:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Decreases the Pain | No Change | Increases the Pain | Additional  Comments: |
| Lying down | ⁪ | ⁪ | ⁪ |  |
| Resting | ⁪ | ⁪ | ⁪ |  |
| Sitting | ⁪ | ⁪ | ⁪ |  |
| Standing | ⁪ | ⁪ | ⁪ |  |
| Walking | ⁪ | ⁪ | ⁪ |  |
| Exercising | ⁪ | ⁪ | ⁪ |  |
| Lifting | ⁪ | ⁪ | ⁪ |  |
| Bending | ⁪ | ⁪ | ⁪ |  |
| Coughing/Sneezing | ⁪ | ⁪ | ⁪ |  |
| Bowel Movements | ⁪ | ⁪ | ⁪ |  |

# FUNCTION: Baseline and Current

Please state how your current condition has changed your level of activity.

|  |  |  |  |
| --- | --- | --- | --- |
| **Functional Activities** | **Before My Condition**  **(Pain, Injury, etc.)** | **Since My Condition I’ve had to modify or avoid these activities**  **Please check and explain**  ⁪ Modifying: ⁪ Avoiding: | |
| Exercising / Training  Type?  How Often? | ⁪ No exercising | ⁪ | ⁪ |
|  |  |  |
| Walking Tolerance  (how far or how long) | ⁪ No limitation | ⁪ | ⁪ |
| Driving a Car | ⁪ Yes ⁪ No | ⁪ | ⁪ |
| Work Activities  ⁪ Office Work  ⁪ Labor | ⁪ No limitation | ⁪ | ⁪ |
| ⁪ No limitation | ⁪ | ⁪ |
| House work / Chores | ⁪ No limitation | ⁪ | ⁪ |
| Yard work | ⁪ No limitation | ⁪ | ⁪ |
| Sleeping | ⁪ No limitation | ⁪ | ⁪ |
| Activities of Daily Living: | ⁪ No limitation | ⁪ | ⁪ |
| Dressing | ⁪ No limitation | ⁪ | ⁪ |
| Bathing | ⁪ No limitation | ⁪ | ⁪ |
| Toileting | ⁪ No limitation | ⁪ | ⁪ |
| Feeding | ⁪ No limitation | ⁪ | ⁪ |
| Shopping | ⁪ No limitation | ⁪ | ⁪ |
| Socializing with Friends | ⁪ No limitation | ⁪ | ⁪ |
| Participating in Recreation | ⁪ No limitation | ⁪ | ⁪ |

**EQUIPMENT: Baseline and Current**

|  |  |  |
| --- | --- | --- |
| Do you require equipment or assistive devices to get around?  ⁪ No  ⁪ Yes (Please Specify) | Before My Condition  (Pain, Injury, etc.) | Since My Condition  (Pain, Injury, etc.) |
| ⁪ Wheelchair ⁪ Scooter | ⁪ Wheelchair ⁪ Scooter |
| ⁪Prosthesis ⁪Orthotic | ⁪Prosthesis ⁪Orthotic |
| ⁪Cane ⁪ Brace | ⁪Cane ⁪ Brace |
| ⁪ Other: | ⁪ Other: |
| ⁪ Other: | ⁪ Other: |

**PREVIOUS DIAGNOSTIC STUDIES:** (Please indicate **DATES** and **RESULTS**, if known):

**MRI**

**CT**

**X-Rays**

Electromyography (**EMG**) and nerve conduction study (**NCS**)

**PREVIOUS AND CURRENT TREATMENTS:**

Please check all of the treatments you have tried for your pain and then complete the appropriate column at the right to the best of your ability.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Treatment | Approximate Date | No Relief | Moderate Relief | Excellent Relief | Additional  Comments |
| ⁪ Osteopathic Treatment (OMT) |  | ⁪ | ⁪ | ⁪ |  |
| ⁪ Physical therapy/exercise |  | ⁪ | ⁪ | ⁪ |  |
| ⁪ Pool therapy |  | ⁪ | ⁪ | ⁪ |  |
| ⁪ Heat treatment |  | ⁪ | ⁪ | ⁪ |  |
| ⁪ Ice |  | ⁪ | ⁪ | ⁪ |  |
| ⁪ Traction |  | ⁪ | ⁪ | ⁪ |  |
| ⁪ TENS |  | ⁪ | ⁪ | ⁪ |  |
| ⁪ Chiropractic |  | ⁪ | ⁪ | ⁪ |  |
| ⁪ Biofeedback/meditation |  | ⁪ | ⁪ | ⁪ |  |
| ⁪ Psychotherapy |  | ⁪ | ⁪ | ⁪ |  |
| ⁪ Steroid or epidural injections |  | ⁪ | ⁪ | ⁪ |  |
| ⁪ Surgery |  | ⁪ | ⁪ | ⁪ |  |
| ⁪ Acupuncture |  | ⁪ | ⁪ | ⁪ |  |
| ⁪ Narcotic medications |  | ⁪ | ⁪ | ⁪ |  |
| ⁪ Other: |  | ⁪ | ⁪ | ⁪ |  |

## 

**Comments:**

**MEDICATIONS** : Please list all current prescribed and over the counter medications as well as herbal supplements and vitamins. Include dose (mg) and how often, e.g. 1, 2, or 3 times a day.

**Medication used to treat your PAIN SYMPTOMS: Does it Relieve Pain? Other Meds**

## Name Dose Current Previous No Relief Moderate Excellent

## \_\_\_\_ € € € € € \_\_\_ \_

## \_\_\_\_ € € € € € \_\_\_ \_

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## \_\_\_\_ € € € € € \_\_\_ \_

## \_\_\_\_ € € € € € \_\_\_ \_

**ALLERGIES (and reaction):**

**Do you have or suspect any latex sensitivity? Yes No**

**PAST MEDICAL HISTORY:**

Aside from your pain problem, how is your general health? (**Please check one)**

€ Excellent € Minor health problems only € Major health problems

# PAST/CURRENT MEDICAL HISTORY: - Check each item

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Current | Past | Never |  | Current | Past | Never |
| Eye Disease | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ | Diabetes | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ |
| Thyroid Disease | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ | Ulcers–Skin, Foot | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ |
| High Blood Pressure | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ | Stroke | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ |
| High Cholesterol | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ | Alzheimer’s | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ |
| Heart attack, disease | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ | Epilepsy, seizures | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ |
| Bleeding Tendency | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ | Osteoarthritis | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ |
| Phlebitis/Blood Clot | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ | Rheumatoid Arthritis | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ |
| Anemia | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ | Fibromyalgia | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ |
| Ulcers–Stomach | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ | Blood Transfusions | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ |
| Kidney Disease or Stones | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ | Liver Disease, Hepatitis | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ |
| Cancer | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ | Alcoholism | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ |
| Lung Disease,  Pneumonia | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ | Mental Illness/ Depression | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ |
| Tuberculosis (positive skin test) | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ | Physical Abuse | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ |
| Asthma | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ | Sexual Abuse | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ |
| Other | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ | Rheumatic Fever | \_\_\_\_\_\_ | \_\_\_\_ | \_\_\_\_\_ |

**ALL SURGERIES (approximate date and type of operation)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

­­­­­­­­­­­­­­­­**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FAMILY HISTORY:**

## If Alive Health (circle one) If Deceased

Father: Age: good fair poor Age:

Cause:

Mother: Age: good fair poor Age:

Cause:

Siblings: Age: good fair poor Age:

Cause:

Age: good fair poor Age:

Cause:

Age: good fair poor Age:

Cause:

Age: good fair poor Age:

Have your grandparents, parents, siblings or children had any of the following? (circle)

High blood pressure Heart disease Heart attacks Stroke

Tuberculosis Epilepsy Alcoholism Cancer

Rheumatic Fever Bleeding tendency Arthritis and/or Gout Asthma

Nervous Breakdown Diabetes Kidney Disease

**SOCIAL BACKGROUND**

Are you (circle): Married Divorced Single Widowed

Are you sharing a residence: Yes No

If yes, is that person’s health (circle): Good Fair Poor

Where do you live? Residence: House Apartment Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Miles to nearest family or friends: \_\_\_\_\_ Do you have any Pets? No Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of children: and their ages:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Personal Habits:** | No | Yes |  | |  |  | |
| Smoke | \_\_\_ | \_\_\_ | Packs per day | \_\_\_ | Number of years | \_\_\_\_ Quit?\_\_\_\_\_\_\_ | |
| Coffee, tea, pop | \_\_\_ | \_\_\_ | Caffeinated | \_\_\_ | Number of cups per day | | \_\_\_ |
| Alcohol | \_\_\_ | \_\_\_ | Average consumption per week \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |

Have you used street drugs? Yes No

Substance: Amount: How long:

Highest education:

Have you ever lived outside the United States? Yes No

If yes, state where and for how long:

Military Service: Yes No

If yes please provide rank:

**Currently Employed:**  Yes If yes, what type of work? \_\_\_\_\_\_ No If not, when did you last work and what type of work did you do? \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Please complete the following information if your problem is the result of an on-the-job injury or if you have retained a lawyer because of this problem or if you expect to receive disability or workmen’s compensation.

Work-related injuries:

Date of injury: Location:

Any litigation pending? Yes No If yes, describe:

Are you applying for disability benefits?: Yes No

From whom?:

**Vaccinations:**  Please indicate if you’ve had the following

Pneumovax € NO € YES Date of most recent vaccination:\_\_\_\_\_\_\_\_\_\_\_\_\_

Influenza € NO € YES Date of most recent vaccination:\_\_\_\_\_\_\_\_\_\_\_\_\_

Varicella Zoster € NO € YES Date of most recent vaccination:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Routine Medical Screening:**

If Abnormal results, please detail below: nl = Normal, abnl = Abnormal

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Most Recent:** | **Date** | **Results** |  |  | **Date** | **Results** |
| Bone Density | \_\_\_\_\_\_\_ | nl / abnl |  | Last Dental Exam | \_\_\_\_\_\_\_ | nl / abnl |
| EKG / Stress Test | \_\_\_\_\_\_\_ | nl / abnl |  | Rectal Exam | \_\_\_\_\_\_\_ | nl / abnl |
| Chest X-ray | \_\_\_\_\_\_\_ | nl / abnl |  | Stool Cards | \_\_\_\_\_\_\_ | nl / abnl |
| Last Physical Exam | \_\_\_\_\_\_\_ | nl / abnl |  | Proctoscopic Exam | \_\_\_\_\_\_\_ | nl / abnl |
| Last Eye Exam | \_\_\_\_\_\_\_ | nl / abnl |  | Colonscopic exam | \_\_\_\_\_\_\_ | nl / abnl |
| **Women Only:** |  |  |  | **Men Only:** |  |  |
| Last Pap: | \_\_\_\_\_\_\_ | nl / abnl |  | PSA-Prostate | \_\_\_\_\_\_\_\_ | nl / abnl |
| Mammogram: | \_\_\_\_\_\_\_ | nl / abnl |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_ |

**Abnormal results:**

**List Other Physicians You Go To:**

|  |  |  |  |
| --- | --- | --- | --- |
| Physician | Specialty | Physician | Specialty |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

## ROS: Please answer for CURRENT symptoms only:

## EYES:

## Do you have blurred / double vision? (circle) YES NO HOW LONG? \_\_

## Do you have recent vision change? YES NO HOW LONG? \_\_

## Do you have Glaucoma / Cataracts? (circle) YES NO HOW LONG? \_\_

# CONSTITUTIONAL:

Are you easily fatigued? YES NO HOW LONG? **\_\_\_\_\_\_\_\_\_**

Unexplained weight loss or gain? (Circle one) YES NO HOW LONG? \_\_\_\_\_\_\_\_\_

Do you have a fever? YES NO HOW LONG? \_\_\_\_\_\_\_\_\_

Do you have chills? YES NO HOW LONG? \_\_\_\_\_\_\_\_\_

Do you have an unexplained decreased appetite? YES NO HOW LONG? \_\_\_\_\_\_\_\_\_

Do you have a cold? YES NO HOW LONG?

**CARDIOVASCULAR:**

Do you have an irregular heart rate? YES NO HOW LONG? \_\_

Have you ever had a heart murmur? YES NO HOW LONG? \_\_

Do you have difficulty exercising due to weakness? YES NO HOW LONG? \_\_\_\_\_\_\_\_

Do you have chest pains? YES NO HOW LONG? \_\_\_\_\_\_\_\_\_\_\_

Do your ankles swell constantly? YES NO HOW LONG? \_\_\_\_\_\_\_\_

**NEUROLOGIC:**

Do you feel like you might faint or feel light-headed? (circle) YES NO HOW LONG?

Do you have numbness/tingling? YES NO HOW LONG?

Do you have unusual headaches? YES NO HOW LONG? \_\_\_\_\_\_

Have you ever had a seizure? YES NO HOW LONG? \_\_\_\_\_\_

Have you ever been paralyzed? YES NO HOW LONG? \_\_\_\_\_\_

Have you ever had a brain injury or concussion? YES NO HOW LONG? \_\_\_\_\_\_

**RESPIRATORY:**

Do you feel short of breath? YES NO HOW LONG?\_\_\_\_\_\_\_

Do you have trouble breathing with any exercise? YES NO HOW LONG? \_\_\_\_\_\_

Do you have a cough? YES NO HOW LONG? \_\_\_\_\_\_

Are you coughing up blood? YES NO HOW LONG? \_\_\_\_\_\_

**GENITOURINARY:**

Do you have pain when you urinate? YES NO HOW LONG?

Do you have or have you had blood in your urine? YES NO HOW LONG?

Are you urinating too often? YES NO HOW LONG?

Do you feel like you have to urinate all the time? YES NO HOW LONG?

Are you unable to control your urine? YES NO HOW LONG?

**GASTROINTESTINAL:**

Do you ever lose control of your bowels? YES NO HOW LONG?

Do you feel sick to your stomach? YES NO HOW LONG?

Have you thrown up, had diarrhea or constipation recently? YES NO HOW LONG?

Have you passed blood with bowel movements? YES NO HOW LONG?

Have you ever had tarry stools? YES NO HOW LONG?

Have you ever had ulcers? YES NO HOW LONG?

Have you ever been jaundice? YES NO HOW LONG?

Have you ever had gallstones? YES NO HOW LONG?

**ENDOCRINE:**

Do you have thyroid disease? YES NO HOW LONG?

Do you have high blood sugar? Excessive thirst? YES NO HOW LONG?

Do you have diabetes- insulin or non-insulin? YES NO HOW LONG?

**INTEGUMENTARY (SKIN):**

Do you have a rash / itch / hives? (circle) YES NO HOW LONG?

Have you had shingles? YES NO HOW LONG?

Do you have breast pain / lump / discharge? (circle) YES NO HOW LONG?

Do you have skin cancer YES NO HOW LONG?

**PSYCHIATRIC:**

Do you have memory loss or confusion? (circle) YES NO HOW LONG?

Do you have nervousness? YES NO HOW LONG?

Do you have depression? YES NO HOW LONG?

Do you have insomnia? YES NO HOW LONG?

**MUSCULOSKELETAL:**

Do you have difficulty moving any limb? YES NO HOW LONG?

Do you have weakness in any limb? YES NO HOW LONG?

Are any of your muscles wasting? YES NO HOW LONG?

Do you have morning stiffness? YES NO HOW LONG?

Do you have joint swelling, redness or pain? (circle) YES NO HOW LONG?

Is your pain worse at night or awaken you from sleep? YES NO HOW LONG?

Have you been in a motor vehicle collision? YES NO When? \_\_\_\_\_\_\_\_

Have you had a whiplash injury? YES NO When? \_\_\_\_\_\_ \_\_\_\_\_\_

Have you ever broken or fractured any bones? YES NO When? \_\_\_\_\_\_

Have you suffered other major/minor trauma? (circle) YES NO When? \_\_\_ \_\_\_\_\_\_

**Patient / Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

**Office use only:**

**Provider Signature:** Date: