Please Print

Client Information

Name _____ Date_____
Date of Birth _____ E-Mail Address_____
Street Address_____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone_____
Occupation_____
Employer _____ Business Phone _____
Sex: □ Male □ Female Height_____ Weight _____
Are you: □ Married □ Single □ Domestic Partnership □ Divorced □ Separated □ Widowed
Spouses Name: _____ # of Children_____
Your Insurance Carrier_____ Claim Number _____
Other Party's Insurance Carrier _____ Claim Number _____
Do you have any special needs? _____

Present Health

Please Complete Duties Under Duress and Loss of Enjoyment Worksheets

Who is your primary care provider? _____
Address _____
Phone _____
Please list any allergies you may have _____
_____
Please list any medications you are currently taking _____
Please list any supplements you are currently taking _____
_____
_____
Describe your current exercise regimen _____
_____
_____
Did you strike your head or any other part of your body in this accident? _____
_____

Medical History

Have you ever been treated by a:

□ Chiropractor □ Naturopathic Doctor
□ Reflexologist □ Massage Therapist
□ Acupuncturist
□Other alternative practitioner

Personal History

List hospitalizations or surgeries have you had with corresponding dates

_____

Have you ever been in an auto accident? _____ When? _____

List other injuries including falls and other traumas and when they occurred:

_____

Have you been diagnosed with any diseases or disorders and when? _____

_____

List childhood immunizations you received _____

Last Tetanus shot

_____

Review of Symptoms

Weight _____ Weight 1 yr. ago _____ Max. Weight _____ When _____

Please Circle the appropriate letter next to each item based on the following:

Y= a condition you have now **N**= never had **P**= a condition you have had in past

Neck Pain	Y P N	Asthma	Y P N
Back Pain	Y P N	Bronchitis	Y P N
Lower Back Pain	Y P N	Pneumonia	Y P N
Extremity Pain	Y P N	Emphysema	Y P N
Chest Pain	Y P N	Difficulty Breathing	Y P N
Right/Left Arm Pain/ Tingling	Y P N	Shortness of Breath	Y P N
Right/Left Leg Pain/Tingling	Y P N	Heart Disease	Y P N
Right/Left Foot Pain/Tingling	Y P N	Angina	Y P N
Right/Left Hand Pain/Tingling	Y P N	High Blood Pressure	Y P N
Fingers/Toes Pain/Tingling	Y P N	Fasciotomy	Y P N
Spasms	Y P N	Edema	Y P N
Dizziness	Y P N	Arthroplasty (prosthetic replacement)	Y P N
Vision Disturbance	Y P N	Nausea	Y P N
Motion Restriction	Y P N	Vomiting	Y P N
Radiating Symptom	Y P N	Constipation	Y P N
Sleep Disruption	Y P N	Blood in Stool	Y P N
Anxiety	Y P N	Gas/Bloating	Y P N
Night Sweats	Y P N	Liver Disease	Y P N
Headaches	Y P N	Hemorrhoids	Y P N
Head Injury	Y P N	Abdominal Pain	Y P N
Impaired Vision	Y P N	Peptic Ulcer	Y P N
Corrected Vision	Y P N	Gall Bladder Disease	Y P N

Depression	Y P N	Pain on Urination	Y P N
Tearing/Dryness	Y P N	Urinary Frequency	Y P N
Double Vision	Y P N	Ligament or Tendon repair, not arthroscopy, Arthrotomy	Y P N
Pallectomy	Y P N	Kidney Stones	Y P N
Cataracts	Y P N	Blood in Urine	Y P N
Impaired Hearing	Y P N	Joint Pain/Stiffness	Y P N
Ear Ringing	Y P N	Arthritis	Y P N
Earaches	Y P N	Broken Bones	Y P N
Frequent Colds	Y P N	Muscle Spasms	Y P N
Sinusitis	Y P N	Deep Leg Pain	Y P N
Postnasal Drip	Y P N	Thrombophlebitis	Y P N
Change in Taste	Y P N	Aspiration of Hematoma	Y P N
Goiter	Y P N	Fainting	Y P N
Cough	Y P N	Seizures	Y P N
Sputum	Y P N	Muscle Weakness	Y P N
Spit up Blood	Y P N	Numbness/Tingling	Y P N
Coordination Difficulties	Y P N	Depression	Y P N
Anxiety	Y P N	Mood Swings	Y P N
Memory Loss	Y P N	Drug/Alcohol Abuse	Y P N
Difficulty Sleeping	Y P N	Phobia	Y P N
Thyroid Problem	Y P N	Extremity Pain – Numbness	Y P N
Arthrotomy, Meniscectomy, cruciate	Y P N	Excessive Thirst	Y P N
Excessive Hunger	Y P N	Anemia	Y P N
Easy Bleeding	Y P N		

Are there any additional health concerns or questions you have?

_____

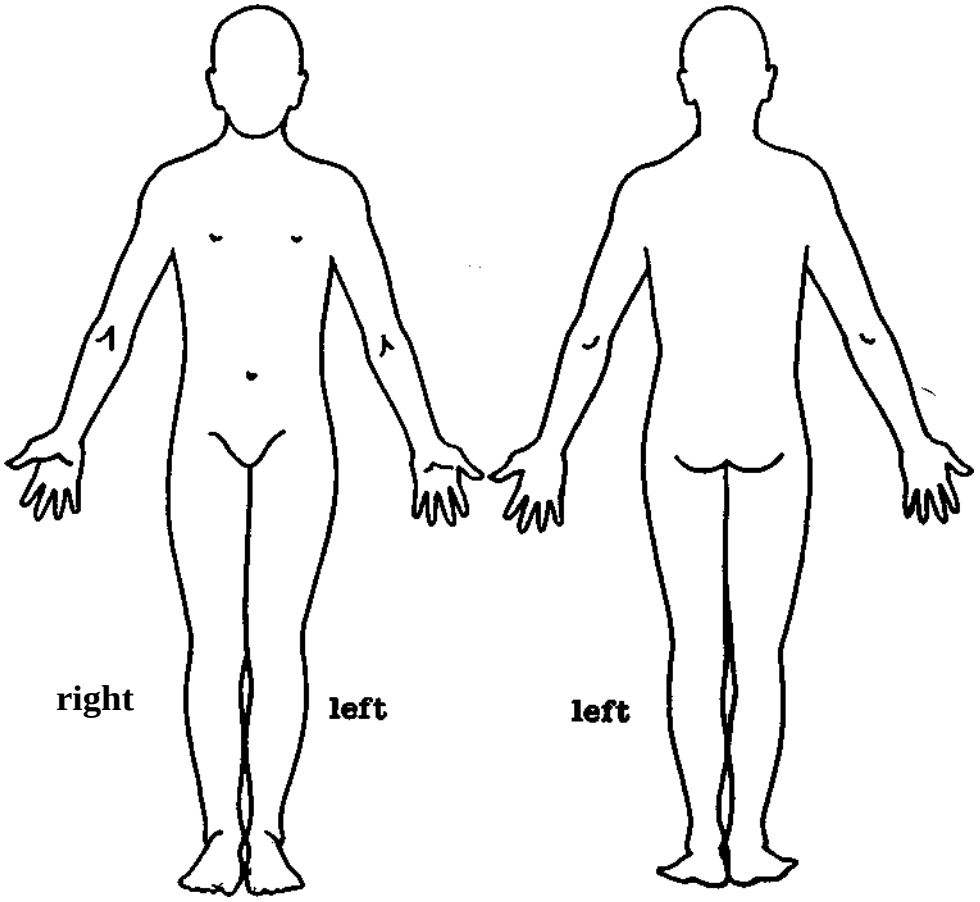
_____

_____

_____

Use the pictures below to indicate your problem areas. Use the appropriate symbol to indicate numbness, pins & needles, burning, stiffness, aching, or stabbing pain.

Numbness: □	Pins & Needles: .-.	Aching pain: ±
Stabbing pain: ↑	Burning: #	Stiffness: u



Please rate your discomfort on a scale of 1-10.
(1= mild pain, 10=the worse pain you've ever felt).

	Location	Pain rating
1.	_____	
2.	_____	
3.	_____	

Patient Name: _____ Date: ___/_____/20___

Duties Under Duress Summary

Complete the following questionnaire as it relates to how your injury(s) affect your performance of your living and work duties. Place a check in front of the day to day **living duties which are painful or difficult for you to perform as a result of the injuries** you sustained in the motor vehicle collision. Then check mark the appropriate box designating reason for difficulty. Include those duties/responsibilities which require that you reduce the time you are capable of performing them.

Job description: _____

N/A	Work	Reason for the difficulty
_____	Lifting	□ Increased Pain □ Restricted movement □ Weakness
_____	Bending	□ Increased Pain □ Restricted movement □ Weakness
_____	Sitting	□ Increased Pain □ Restricted movement □ Weakness
_____	Walking	□ Increased Pain □ Restricted movement □ Weakness
_____	Computer duties	□ Increased Pain □ Restricted movement □ Fatigue
Other: _____		□ Increased Pain □ Restricted movement □ Weakness

N/A	Studies/School	Reason for the difficulty
_____	Lifting	□ Increased Pain □ Restricted movement □ Weakness
_____	Bending	□ Increased Pain □ Restricted movement □ Weakness
_____	Sitting	□ Increased Pain □ Restricted movement □ Weakness
_____	Walking	□ Increased Pain □ Restricted movement □ Weakness
_____	Computer duties	□ Increased Pain □ Restricted movement □ Fatigue
_____	Studying	□ Increased Pain □ Restricted movement □ Fatigue
Other: _____		□ Increased Pain □ Restricted movement □ Weakness

N/A	Domestic Duties	Reason for the difficulty
_____	Vacuuming	□ Increased Pain □ Restricted movement □ Fatigue
_____	Taking care of kids	□ Increased Pain/Anxiety □ Restricted movement □ Fatigue
_____	Cleaning	□ Increased Pain □ Restricted movement □ Fatigue
_____	Preparing Meals	□ Increased Pain □ Restricted movement □ Fatigue
_____	Other: _____	□ Increased Pain/Anxiety □ Restricted movement □ Fatigue

N/A	Household Duties	Reason for the difficulty
_____	Yardwork	□ Increased Pain □ Restricted movement □ Fatigue
_____	Transportation	□ Increased Pain/Anxiety □ Restricted movement □ Fatigue
_____	Shopping	□ Increased Pain/Anxiety □ Restricted movement □ Fatigue
_____	Taking out trash	□ Increased Pain □ Restricted movement □ Weakness
_____	Other: _____	□ Increased Pain/Anxiety □ Restricted movement □ Fatigue

Patient Name: _____ Date: _____/_____/20___

Loss of Enjoyment Summary

Complete the following questionnaire as it relates to the **activities** (work related or otherwise) **you normally would be enjoying** - but are **currently not enjoying** as a result of your injury(s).
Include all activities which you:

- can no longer do or perform, and/or
- cannot do or perform as often as you did before your injury

Job description_____

N/A	Work	Reason for the limitation
_____	Lifting	□ Increased Pain □ Restricted movement □ Weakness
_____	Bending	□ Increased Pain □ Restricted movement □ Weakness
_____	Walking	□ Increased Pain □ Restricted movement □ Fatigue
_____	Computer duties	□ Increased Pain □ Restricted movement □ Fatigue
Other: _____		□ Increased Pain/Anxiety □ Restricted movement □ Fatigue

N/A	Studies/School	Reason for the limitation
_____	Lifting	□ Increased Pain □ Restricted movement □ Weakness
_____	Bending	□ Increased Pain □ Restricted movement □ Weakness
_____	Sitting	□ Increased Pain □ Restricted movement □ Fatigue
_____	Walking	□ Increased Pain □ Restricted movement □ Fatigue
_____	Computer duties	□ Increased Pain □ Restricted movement □ Fatigue
_____	Studying	□ Increased Pain □ Restricted movement □ Fatigue
Other: _____		□ Increased Pain □ Restricted movement □ Fatigue

N/A	Domestic Duties	Reason for the limitation
_____	Vacuuming	□ Increased Pain □ Restricted movement □ Fatigue
_____	Taking care of kids	□ Increased Pain/Anxiety □ Restricted movement □ Fatigue
_____	Cleaning	□ Increased Pain □ Restricted movement □ Fatigue
_____	Preparing Meals	□ Increased Pain □ Restricted movement □ Fatigue
_____	Other: _____	□ Increased Pain □ Restricted movement □ Fatigue

N/A	Household Duties	Reason for the limitation
_____	Yardwork	□ Increased Pain □ Restricted movement □ Fatigue
_____	Transportation	□ Increased Pain/Anxiety □ Restricted movement □ Fatigue
_____	Shopping	□ Increased Pain/Anxiety □ Restricted movement □ Fatigue
_____	Taking out trash	□ Increased Pain □ Restricted movement □ Weakness
_____	Other: _____	□ Increased Pain □ Restricted movement □ Weakness

N/A	Sports	Reason for the limitation

Name Sport: _____ □ Increased Pain □ Restricted movement □ Weakness
Pre-accident level of participation: □ Socially □ Competitively □ Professionally