PATIENT # _____ Date ____ / ____ / ____

CONFIDENTIAL CLINICAL RECORD

GENERAL INFORMATION - PLEASE PRINT

PATIENT NAME _____ HOME ADDRESS _____

CITY _____ STATE ____ ZIP CODE _____ HOW LONG? _____

PREVIOUS ADDRESS IF LESS THAN 3 YEARS AT PRESENT ADDRESS _____ CITY _____ STATE ____ ZIP CODE _____

BIRTHDATE ____ / ____ / ____ SEX: M — F ___ MARITAL STATUS M _ S _ D _ W _ CHILDREN _____

YOUR EMPLOYER _____ CITY _____ YEARS WITH FIRM _____

OCCUPATION _____ SOCIAL SECURITY # ____ / ____ / ____

DRIVERS LICENSE NO. _____ HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ EMAIL _____

SPOUSE'S NAME _____ S.S. # ____ / ____ / ____ OCCUPATION _____

SPOUSE'S EMPLOYER _____ CITY _____ HOW LONG? _____

NEAREST RELATIVE NOT LIVING WITH YOU _____

ADDRESS _____ CITY _____ PHONE _____

PHYSICIAN _____ DATE OF LAST PHYSICAL _____

DENTIST _____ DATE OF LAST VISIT _____

DATE OF LAST CHIROPRACTIC ADJUSTMENT ____ / ____ / ____ SEEN BY DR. _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? _____

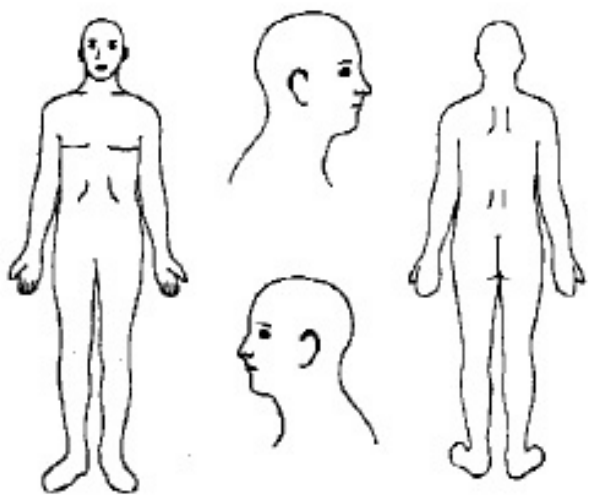
ADDRESS IF DIFFERENT _____ PHONE _____

WHO MAY WE CONTACT IN CASE OF EMERGENCY? _____

PHONE _____ WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, constant, off & on, when standing, when sitting, etc., etc.

COMPLETE THESE DIAGRAMS



MAJOR COMPLAINT

(Describe in your own words your problem and how it happened or started)

_____

_____

_____

_____

_____

_____

When was the very first time you were aware of this problem?

_____

Have you ever had this problem or similar problem before? ____

If yes, explain: _____

_____

_____

Have you ever received any treatment for this condition? ____
If yes, when, where and what were the results?

_____

_____

_____

_____

Is the problem better ☐ worse ☐ the same ☐

What makes it better? _____

What makes it worse? _____

_____

PLEASE COMPLETE REVERSE SIDE

How has this problem affected your life:

A. Home _____

B. Work _____

C. Recreation _____

D. Rest and Sleep _____

List all surgery you have had and the dates

_____

_____

_____

_____

Have you ever been in an automobile accident? ☐ Never ☐ Past Yr. ☐ Past 5 Years ☐ Over 5 Yrs.

Describe any other accidents or falls you have ever had _____

_____

Have you ever? Been stunned or unconscious ☐ Had broken bones ☐ Used a cane or crutch ☐ Been hospitalized ☐ What for _____

Had a nervous breakdown ☐

Had any major illness ☐ Describe _____

DRUGS YOU NOW TAKE: ☐ Nerve Pills ☐ Pain Killers ☐ Muscle Relaxers ☐ "Pep" Pills ☐ Tranquilizers ☐ Insulin ☐ Birth Control Pills ☐ Other (please list) _____

Have you or any of your blood relatives had? ☐ High Blood Pressure ☐ Venereal Disease ☐ Tuberculosis ☐ Heart Disease ☐ Diabetes ☐ Arthritis ☐ Epilepsy ☐ Cancer ☐ Polio

Habits: fill in number or check those that apply

No. hours sleep ____ Exercise routinely ☐ Do you smoke ☐

How many cups or glasses ____ ☐ tea ____ ☐ coffee ____ ☐ soda ____ ☐ alcohol

Please underline all of the following symptoms which you have now or have had previously. We want all the facts about your health before we accept your case. Your health report is confidential and is treated as such by our staff.

GENERAL SYMPTOMS

784.0	Headache
346.9	Migraine headache
780.8	Night Sweating
780.2	Fainting
780.4	Dizziness
780.3	Convulsions
780.52	Loss of sleep
780.7	Fatigue
799.2	Nervousness
783	Loss of weight
278.0	Obesity
995.3	Allergy
781	Tremors

E.E.N.T.

368.9	Failing vision
389.9	Deafness
388.70	Earache
388.30	Ear noises
784.7	Nose bleeds
462	Sore throat
493.9	Asthma
460	Frequent colds
240.9	Enlarged thyroid
686.9	Sinus problems

SKIN

698.9	Itching
287.8	Bruises easily
701.1	Dryness
454.9	Varicose veins
782	Sensitive skin

RESPIRATORY

786.2	Chronic cough
786.50	Chest pain
786.09	Pain or difficulty breathing with exercise

CARDIO-VASCULAR

785	Rapid beating heart
427.89	Slow beating heart
401.9	High blood pressure
458.9	Low blood pressure
786.51	Pain over heart
719.07	Swelling of ankles Right ☐ Left ☐
436	Paralytic stroke

MUSCLE & JOINT SYMPTOMS

716.9	Arthritis
782	Numbness/pain in arms hands, or legs, toes
719	Swollen joints
719.7	Difficulty in walking
722.10	Low back pain
722.2	Disc displacement
723.1	Pain in neck
723.5	Stiff neck
724.1	Pain between shoulders
724.79	Painful tailbone
728.85	Muscle spasms
729.4	Foot trouble
737	Faulty posture
737.3	Spinal curvature
781	Tremors
_____	Shoulder pain
_____	Knee pain
_____	Elbow pain
_____	Ankle pain

GENITOURINARY SYMPTOMS

788.3	Frequent urination
788.1	Painful urination
592	Kidney infection/stones
601.9	Prostate trouble

GASTROINTESTINAL SYMPTOMS

783	Poor appetite
994.2	Excessive hunger
787.3	Belching or gas
787	Nausea or Vomiting
536.8	Pain over stomach
564	Constipation
558.9	Diarrhea
789	Colon trouble
455.6	Hemorrhoids (Piles)
575.9	Gall bladder trouble
558.9	Colitis

FOR WOMEN ONLY

611.72	Lumps in breast
623.5	Vaginal discharge
625.3	Painful menstrual periods
626.2	Excessive flow
626.4	Irregular cycle
627.2	Menopausal symptoms

Date of last period ____ / ____ / ____

Are you pregnant? _____

Number of pregnancies _____

Number of live births _____

Birth Control method _____

Signature _____

Patient/Guardian

PERSONAL INJURY/WORKMEN'S COMPENSATION QUESTIONNAIRE

NAME: _____ Date of Accident: _____ Time: _____

Where did accident happen? _____

Describe the accident in your own words: _____

_____

_____

What was your position in car? ☐ Driver ☐ Passenger. If passenger, were you sitting in ☐ Front ☐ Right Rear ☐ Left Rear

Did your vehicle strike other vehicle? ☐ Yes ☐ No. Was your car struck by other vehicle? ☐ Yes ☐ No

Was the impact from ☐ the front? ☐ from the right side? ☐ from the left side? ☐ from the rear?

At the time of impact, were you ☐ looking straight ahead? ☐ looking right? ☐ looking left?

Were both hands on steering wheel? ☐ Yes ☐ No Was your foot on brake? ☐ Yes ☐ No Were you braced for impact? ☐ Yes ☐ No

Where in the car were you after the accident? _____

Were you wearing seat belts? ☐ Yes ☐ No Did you strike anything in vehicle at time of impact? ☐ Yes ☐ No

If yes, specify: ☐ Steering Wheel ☐ Dashboard ☐ Windshield ☐ Side Door ☐ Arm Rests

☐ Side Window. Please state part of body: ☐ Chest ☐ Chin ☐ Knee ☐ Shoulder ☐ Hand ☐ Head

Immediately following the accident, how did you feel? _____

_____

Were you unconscious? ☐ Yes ☐ No In a daze? ☐ Yes ☐ No Did you go to hospital? ☐ Yes ☐ No

If you went to hospital, when? At time of accident ☐ Yes ☐ No Next day ☐ Yes ☐ No

How did you get to hospital? Ambulance ☐ Yes ☐ No Private Transportation ☐ Yes ☐ No

Did the ambulance attendants place you in: Neck Collar ☐ Yes ☐ No Splints ☐ Yes ☐ No Brace ☐ Yes ☐ No

Name of Hospital: _____

Attended by Dr. _____ Were you x-rayed at hospital? ☐ Yes ☐ No

If so, what was the diagnosis? _____

Were you admitted to the hospital? ☐ Yes ☐ No How long did you stay? _____

What treatment was rendered? _____

What recommendations were made? See own doctor? ☐ Yes ☐ No See orthopedic doctor ☐ Yes ☐ No

Physical Therapy ☐ Yes ☐ No

Have you seen any other doctor as a result of this accident? ☐ Yes ☐ No

Doctor's name _____

Is your pain constant? ☐ Yes ☐ No Is the pain on and off? ☐ Yes ☐ No Sharp? ☐ Yes ☐ No Dull? ☐ Yes ☐ No

Other _____

Is your pain worse when arising from a chair? ☐ Yes ☐ No Is it made worse by straining? ☐ Yes ☐ No By coughing? ☐ Yes ☐ No

By sneezing? ☐ Yes ☐ No By straining when moving your bowels? ☐ Yes ☐ No

Do you have any numbness or tingling in your arms ☐ Yes ☐ No In your hands? ☐ Yes ☐ No In your fingers? ☐ Yes ☐ No

In your legs? ☐ Yes ☐ No In your feet? ☐ Yes ☐ No In your toes? ☐ Yes ☐ No

What is your most comfortable position? Sitting ☐ Yes ☐ No Lying on your right side ☐ Yes ☐ No On your left side ☐ Yes ☐ No

Lying on your back ☐ Yes ☐ No On your stomach ☐ Yes ☐ No Standing ☐ Yes ☐ No

Other _____ Is it difficult for you to move around in bed? ☐ Yes ☐ No

Does stretching and twisting worsen the pain? ☐ Yes ☐ No

Do any of the following relieve your pain? ☐ Heating Pad ☐ Hot Bath ☐ Shower ☐ Ice Pack

Does a brace (if you have tried one) help relieve the pain? ☐ Yes ☐ No

Does a change in heel height worsen the pain? ☐ Yes ☐ No Do you feel better moving around? ☐ Yes ☐ No Or resting? ☐ Yes ☐ No

Do you have a firm mattress? ☐ Yes ☐ No Do your knees ache or hurt? ☐ Yes ☐ No Do you have cramps in leg? ☐ Yes ☐ No

In arm? ☐ Yes ☐ No Have you had any change in your bowel habits? ☐ Yes ☐ No

Have you lost any time from work because of this accident? ☐ Yes ☐ No

If yes, give dates of time lost. From _____ To _____

Totally disabled from _____ to _____ Partially disabled from _____ to _____

BEFORE YOUR ACCIDENT, estimate your total lifting effort ability:

1. How much weight? ☐ Maximum ☐ Average
2. How far could you carry this weight? _____ For how long a period of time? _____
3. Was this lifting done at work? ☐ Yes ☐ No Or at home or elsewhere? ☐ Yes ☐ No
4. How often did you carry this amount of weight? _____

AFTER YOUR ACCIDENT, describe your total lifting ability:

1. How much weight can you now lift without experiencing pain, discomfort, or restriction of motion? _____
2. Did you experience this pain, discomfort, or restriction of motion before your accident? ☐ Yes ☐ No
3. How far can you carry this weight how? _____ And for how long a period of time? _____
4. How often can you carry this weight? _____
5. Are you now limited in your lifting ability in some body position that you were previously not? ☐ Yes ☐ No
   If so, specify position _____
6. What symptoms does lifting produce? _____
7. How long do these symptoms last? _____

Are you presently able to:

LIFT ☐ Very heavy_____ lbs. ☐ Heavy_____ lbs. ☐ Light _____lbs. ☐ Sitting_____ lbs.

WORK ☐ Very heavy_____ lbs. ☐ Heavy_____ lbs. ☐ Light_____ lbs. ☐ Sitting_____ lbs.

What positions can you work in with a MINIMUM DEMAND of physical effort? ☐ Standing ☐ Walking ☐ Sitting

With Minimum Demand of physical effort, what positions can you work in PART-TIME and for how long?

☐ Standing ☐ Walking ☐ Sitting

With Minimum Demand of physical effort, can you work in a SITTING POSITION with some degree of walking or standing activity?

☐ Yes ☐ No

Do you feel that you cannot perform any physical work activity? ☐ Yes ☐ No

Do you feel that you cannot perform any mental work? ☐ Yes ☐ No

Relate your BEFORE injury capacity (mark 'B') and your AFTER injury capacity (mark 'A') for performing activities:

1.	Walking	Normal	_____	Limited	_____	Difficult	_____	Pain_____
2.	Standing	Normal	_____	Limited	_____	Difficult	_____	Pain_____
3.	Sitting	Normal	_____	Limited	_____	Difficult	_____	Pain_____
4.	Bending	Normal	_____	Limited	_____	Difficult	_____	Pain_____
5.	Stooping	Normal	_____	Limited	_____	Difficult	_____	Pain_____
6.	Lifting	Normal	_____	Limited	_____	Difficult	_____	Pain_____
7.	Pushing	Normal	_____	Limited	_____	Difficult	_____	Pain_____
8.	Pulling	Normal	_____	Limited	_____	Difficult	_____	Pain_____
9.	Climbing	Normal	_____	Limited	_____	Difficult	_____	Pain_____
10.	Reaching	Normal	_____	Limited	_____	Difficult	_____	Pain_____
11.	Gripping	Normal	_____	Limited	_____	Difficult	_____	Pain_____
12.	Kneeling	Normal	_____	Limited	_____	Difficult	_____	Pain_____
13.	Balance	Normal	_____	Limited	_____	Difficult	_____	Pain_____
14.	Fatigue	Normal	_____	Limited	_____	Difficult	_____	Pain_____

Generally speaking, is your inability to perform these functions due to ☐ Pain ☐ Weakness ☐ Structural limitations ☐ Nerves?

Do you have normal sexual function? ☐ Yes ☐ No

Are you able to take care of your personal self, such as dressing, bathing, etc.? ☐ Yes ☐ No Or do you require assistance? ☐ Yes ☐ No

Do you feel your present condition is temporary? ☐ Yes ☐ No Or permanent? ☐ Yes ☐ No

Patient's Signature _____ Date: _____

IN THE EVENT OF AN AUTOMOBILE ACCIDENT, THERE ARE MANY POSSIBLIES FOR FILING ON INSURANCE. OUR OFFICE WILL STRIVE TO FILE ON WHATEVER FUNDS MAY BE AVAILABLE TO YOU; HOWEVER THE PATIENT IS RESPONSIBLE FOR ALL CHARGES THAT ARE NOT PAID BY THE INSURANCE COMPANY.

YOUR AUTO INSURANCE INFORMATION

*Name on Policy:*_____ *Phone:*_____
*Date of Accident:*_____ *Name of Insurance:*_____
*Policy#:*_____ *Claim#:*_____

DRIVER'S AUTO INSURANCE(if you were passenger)

*Name on Policy:*_____ *Name of Insurance:*_____
*Policy#*_____ *Claim#:*_____

LIABILITY (PERSON AT FAULT FOR ACCIDENT)

*Insured'sName:*_____
*Name of Insurance:*_____
*Policy#:*_____ *Claim#:*_____
*Adjuster Name:*_____ *Phone:*_____

HEATH INSURANCE

*Name of Insured:*_____ *Policy#:*_____
*Group#:*_____ *ID#:*_____
*Insurance Company:*_____
*Phone#:*_____
*Employer:*_____ *Phone:*_____

ATTORNEY INFORMATION

Law Office of _____ *Phone#:*_____
*Case Worker:*_____