

# 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.

### 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?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

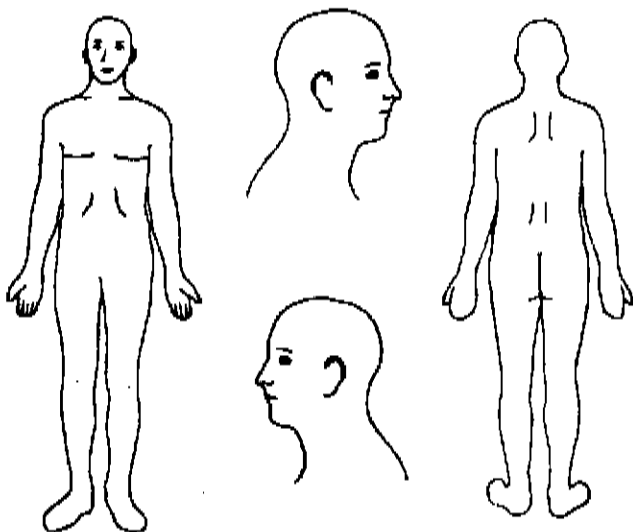
Is the problem better  worse  the same

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

\_\_\_\_\_

### COMPLETE THESE DIAGRAMS



How has this problem affected your life:

List all surgery you have had and the dates

- A. Home \_\_\_\_\_
- B. Work \_\_\_\_\_
- C. Recreation \_\_\_\_\_
- D. Rest and Sleep \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

**RESPIRATORY**

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

**GENITOURINARY SYMPTOMS**

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

**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

**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

**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

**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

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

**SKIN**

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

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: \_\_\_\_\_

WORKER'S COMPENSATION INSURANCE

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

DATE OF INJURY \_\_\_\_\_ WAS IT REPORTED? \_\_\_\_\_

WHEN AND TO WHOM? \_\_\_\_\_

EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

WORK SUPERVISOR \_\_\_\_\_

ATTORNEY INFORMATION

LAW OFFICE OF \_\_\_\_\_

ATTORNEY ON RECORD \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_

IN THE EVENT THAT AN ATTORNEY HAS BEEN INVOLVED THE PATIENT MUST NOTIFY OUR OFFICE WITHIN 24 HOURS. IF AN ATTORNEY HAS CHANGED OR BEEN DISMISSED OR RELEASED THE CASE THEN PATIENT MUST NOTIFY OUR OFFICE WITHIN 24 HOURS.