

PATIENT INJURY/MEDICAL HISTORY FORM

Name _____ Date _____
Social Security Number: _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Email _____ Emergency Contact _____ Phone _____
Date of Collision: _____ Patient Height: _____' _____" Patient Weight: _____ lbs.
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: \$ _____
Personal Auto Insurance: _____ Phone _____ Claim# _____
Do you have Medical Pay per your personal policy? [] Yes Max Amount? \$ _____ [] No [] Unsure
At Faults Auto Insurance: _____ Phone _____ Claim# _____
Describe Accident: _____

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

You 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
Did you experience: [] Shock [] Loss of Consciousness
Concussion Diagnosis [] YES [] No
Air bag Deployed [] YES [] No
State your Emotions and Physical State Immediately Following the accident:

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
[] Other: Explain below:

The Road was: The Weather Conditions were:
[] Dry [] Sunny [] Light rain
[] Wet [] Cloudy [] Heavy rain
[] Icy [] Foggy [] Snowing
[] Snowy
Time of Day: [] Dawn [] Day [] Dusk [] Night [] Unknown

Symptomatology (Pain Characteristics for Major Area of Complaint):

The pain started _____
The pain is made: Better by _____ 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 paresthesia (tingling/numbness) into: _____
The pain is located _____
The pain is (as far as timing is concerned: i.e. comes & goes, constant, etc.) _____

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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

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Social History

- Single Smoker
- Married Non-Smoker
- Divorced Drinks Alcohol
- Number of Children: _____ Does not drink Alcohol
- Takes Drugs
- Does not take Drugs

List your Hobbies & Exercise Activities

Number one concern if this injury is not treated correctly?

Occupational History

Your Employer _____

Job Title _____

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

What is your current job satisfaction:

- Very Satisfied
- Satisfied
- Dissatisfied
- Very Dissatisfied

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

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

- X-rays Discogram
- CT Scan Bone Scan
- Myelogram EMG
- MRI Scan NCV test

List Past Surgeries: None

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

List Past Hospitalizations: None

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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

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

- Yes
- No

Do you have any current problem with:

- anxiety
- depression
- irritability

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

Please take a moment and carefully read the following information, and sign where indicated.

I, _____ (Print Name) hereby give my informed consent to receive chiropractic treatment from Premier Family Chiropractic. Chiropractic involves the adjustment, manipulation, and treatment of your body in which vertebral subluxations and other articulations and structures may be interfering with the normal, transmission, and expression of nerve impulses between the brain, organs, muscles, joints, and tissues of the body. Chiropractic adjustments are intended to restore the normal flow of nerve impulses which produce proper nervous system function reducing pain and improving one's health. I further understand and agree that health/auto insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered and charged is my personal responsibility for timely payment. I also understand that there is no guarantee of payment from the auto/health insurance. If auto/health Insurance does not cover the care rendered payment will be due personally to our clinic. If I terminate my care/treatment before all treatments recommended are complete, or miss visits this could affect payment on the claim and any fees for professional services rendered to me are immediately due and payable. If the balance is not paid in a timely manner and has to be moved offsite to be collected a 30% fee charge will be added to the outstanding balance to cover external costs.

Signature: _____ Date: ____/____/____