ACCIDENT / INJURY FORM

NAME: ___________________________ DATE: _____________________

1. Date of your accident or when your problem began: _______________________

2. Did any of these symptoms exist prior to this accident?
   Yes _____ No ______ if yes, please describe where and when: ______________

3. Is there light duty available at work? Yes _____ No ______

4. Please describe your major job duties: ______________________________________

5. What treatment have you received for this injury already? ______________________


7. How often does it happen? _______________________________________________

8. What makes it worse? _____________________________________________________

9. What makes it better? _____________________________________________________

10. Is there any stiffness? ______ Where? _________________________________

11. Is there numbness? ______ Where? _________________________________

12. Is there any tingling? ______ Where? _________________________________


16. Locking? ______ Where? _________________________________


C. Describe your accident / injury or problem in detail: ______________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
NAME: _____________________________________________ DATE: __________

Medication Allergies: __________________________________________________________
____________________________________________________________________________

Current Medications: ___________________________________________________________
____________________________________________________________________________

List all surgical procedures: _____________________________________________________
____________________________________________________________________________

Do you have or have you had any of the following medical conditions? Circle your answer.

Hypertension: Yes No
Heart disease: Yes No
Stroke: Yes No
Diabetes: Yes No
Asthma: Yes No
Emphysema: Yes No
Peptic ulcers: Yes No
Kidney disease: Yes No
Hepatitis: Yes No
Cancer: Yes No
Thyroid disease: Yes No
Osteoporosis: Yes No
Arthritis: Yes No

List any other medical conditions you have: ________________________________________
____________________________________________________________________________

Are there any diseases that run in your family? ____________________________________
____________________________________________________________________________

Do you smoke? Yes No
Do you consume alcohol? Yes No
Are you currently pregnant? Yes No

How many children have you had? (Females only) ____________________________
NAME: _____________________________________________    DATE: ____________

REVIEW OF SYSTEMS

Which of the following do you have?

<table>
<thead>
<tr>
<th>Skin/Lymphatic</th>
<th>Genitourinary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rash or itching</td>
<td>Burning urination</td>
</tr>
<tr>
<td>Skin infections</td>
<td>Blood in urine</td>
</tr>
<tr>
<td>Non-healing sores</td>
<td>Frequent urination</td>
</tr>
<tr>
<td>Swollen glands</td>
<td>Kidney stones</td>
</tr>
<tr>
<td>Breast lump</td>
<td>Male testicle pain</td>
</tr>
<tr>
<td>New skin spots</td>
<td>Female irregular period</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neurologic</th>
<th>Allergies/Immune Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fainting</td>
<td>Anaphylactic reaction</td>
</tr>
<tr>
<td>Seizures/Convulsions</td>
<td>Latex allergy</td>
</tr>
<tr>
<td>Dizziness</td>
<td>Rheumatoid disease</td>
</tr>
<tr>
<td>Memory loss</td>
<td>Environmental allergy</td>
</tr>
<tr>
<td>Severe headaches</td>
<td></td>
</tr>
<tr>
<td>Paralysis or stroke</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eyes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Glaucoma</td>
<td></td>
</tr>
<tr>
<td>Vision problems</td>
<td></td>
</tr>
<tr>
<td>Wear glasses/contacts</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ears/Nose/Throat</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hoarseness</td>
<td></td>
</tr>
<tr>
<td>Nose bleeds</td>
<td></td>
</tr>
<tr>
<td>Hearing loss</td>
<td></td>
</tr>
<tr>
<td>Ringing in the ears</td>
<td></td>
</tr>
<tr>
<td>Difficulty swallowing</td>
<td></td>
</tr>
<tr>
<td>Tooth pain or infection</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Endocrine</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Thyroid Disease</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hematologic</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bleed/bruise easily</td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
</tr>
<tr>
<td>Slow healing wounds</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychological</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Nervousness/insomnia</td>
<td></td>
</tr>
<tr>
<td>Mental illness</td>
<td></td>
</tr>
<tr>
<td>Anxiety/depression</td>
<td></td>
</tr>
</tbody>
</table>
PAIN DRAWING

Instructions:
Mark these drawings according to where you hurt (if the back of your neck hurts, mark the drawing on the back of the neck, etc.). If you feel any of the following symptoms, please indicate which sensations you feel by placing the marks shown below.

KEY

/// for Stabbing
XXX for Burning
OOO Pins & Needles
=== Numbness
+++ Aching

PAIN LEVEL: (Circle one)

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>(no pain)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(severe pain)</td>
</tr>
</tbody>
</table>