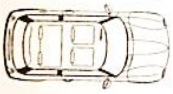
ACCIDENT / INJURY FORM

NAME: _____ DATE: _____

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

A. Motor Vehicle Accident:	B. Work Related Injury:
Yes ____ No ____	Yes ____ No ____
Driver ____ Passenger ____	
Seat Belt ____ Air Bag Deployed ____	Has the injury been accepted as a Worker's Compensation Claim?
Indicate site of impact:	Yes ____ No ____
"P" = Primary "S" = Secondary	
	
Did you hit your head? Yes ___ No ___	
Any loss of consciousness? Yes ___ No ___	
Memory problems? Yes ___ No ___	

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

_____

_____

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? _____
   _____
6. Does your present pain travel? _____ Where? _____
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? _____
13. Any weakness? _____ Where? _____
14. Any swelling? _____ Where? _____
15. Grinding? _____ Where? _____
16. Locking? _____ Where? _____
17. Give away? _____ Where? _____

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?

Skin/Lymphatic			**Genitourinary**		
Rash or itching	Yes	No	Burning urination	Yes	No
Skin infections	Yes	No	Blood in urine	Yes	No
Non-healing sores	Yes	No	Frequent urination	Yes	No
Swollen glands	Yes	No	Kidney stones	Yes	No
Breast lump	Yes	No	Male testicle pain	Yes	No
New skin spots	Yes	No	Female irregular period	Yes	No
Neurologic			**Allergies/Immune Disorders**		
Fainting	Yes	No	Anaphylactic reaction	Yes	No
Seizures/Convulsions	Yes	No	Latex allergy	Yes	No
Dizziness	Yes	No	Rheumatoid disease	Yes	No
Memory loss	Yes	No	Environmental allergy	Yes	No
Severe headaches	Yes	No			
Paralysis or stroke	Yes	No	**Gastrointestinal**		
			Heartburn	Yes	No
Eyes			Abdominal pain	Yes	No
Glaucoma	Yes	No	Nausea/vomiting	Yes	No
Vision problems	Yes	No	Blood in stool	Yes	No
Wear glasses/contacts	Yes	No	Loss of appetite	Yes	No
			Peptic ulcer	Yes	No
Ears/Nose/Throat			Frequent diarrhea	Yes	No
Hoarseness	Yes	No			
Nose bleeds	Yes	No	**Musculoskeletal**		
Hearing loss	Yes	No	Joint pain	Yes	No
Ringing in the ears	Yes	No	Joint swelling	Yes	No
Difficulty swallowing	Yes	No	Back pain	Yes	No
Tooth pain or infection	Yes	No	Muscle pain	Yes	No
			Cold extremities	Yes	No
Endocrine					
Diabetes	Yes	No	**Constitutional**		
Thyroid Disease	Yes	No	Fatigue	Yes	No
			Recent weight change	Yes	No
Hematologic			Fever	Yes	No
Bleed/bruise easily	Yes	No	Good general health lately	Yes	No
Anemia	Yes	No			
Slow healing wounds	Yes	No	**Cardiovascular**		
			Chest pain	Yes	No
Psychological			Palpitations	Yes	No
Nervousness/insomnia	Yes	No	Heart trouble	Yes	No
Mental illness	Yes	No	Hypertension	Yes	No
Anxiety/depression	Yes	No	Swelling feet, ankles, hands	Yes	No

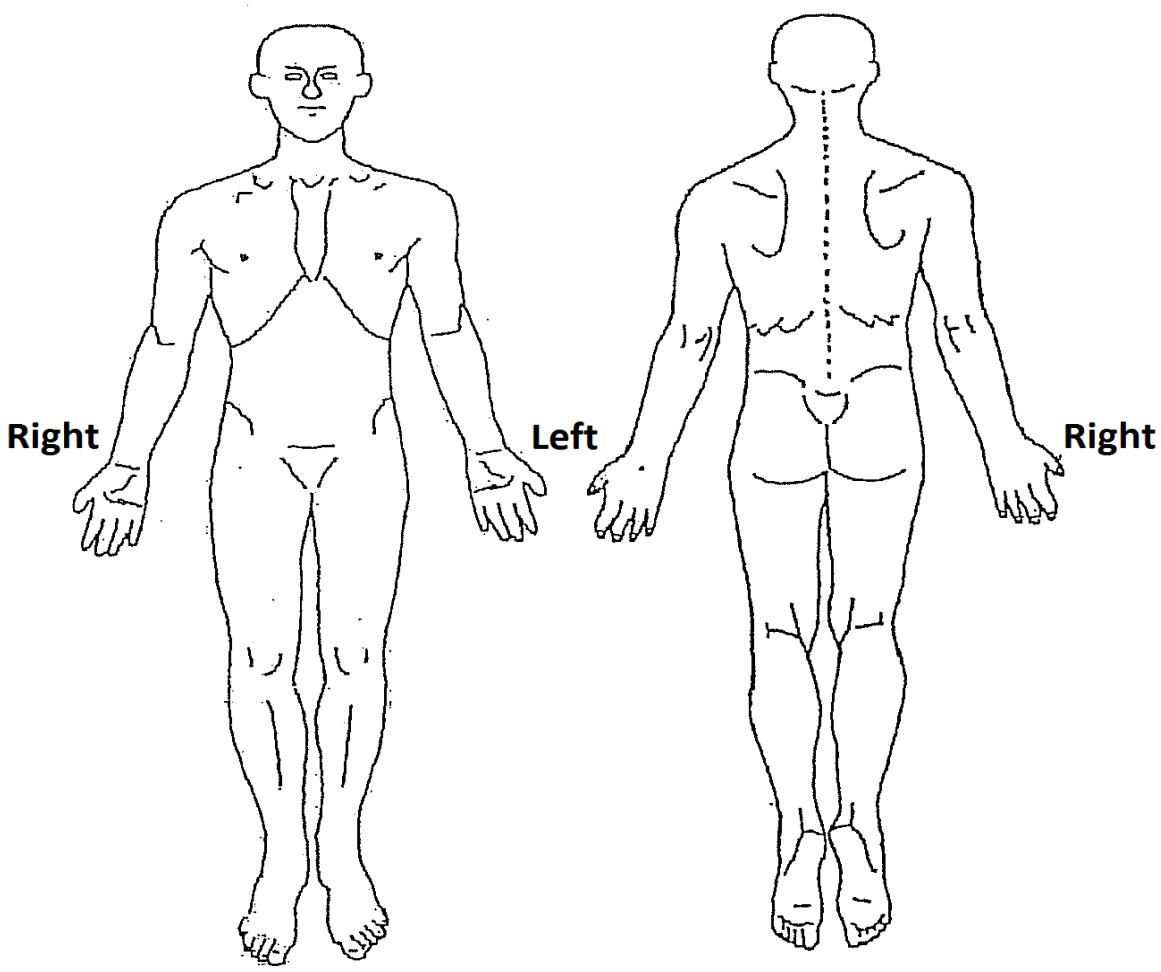
PAIN DRAWING

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)

0 1 2 3 4 5 6 7 8 9 10

(no pain) (severe pain)