HISTORY OF PHYSICAL COMPLAINTS

NAME _____ OCCUPATION _____ AGE _____
PLEASE PRINT

Address _____ Telephone _____

Describe present complaint/injury _____

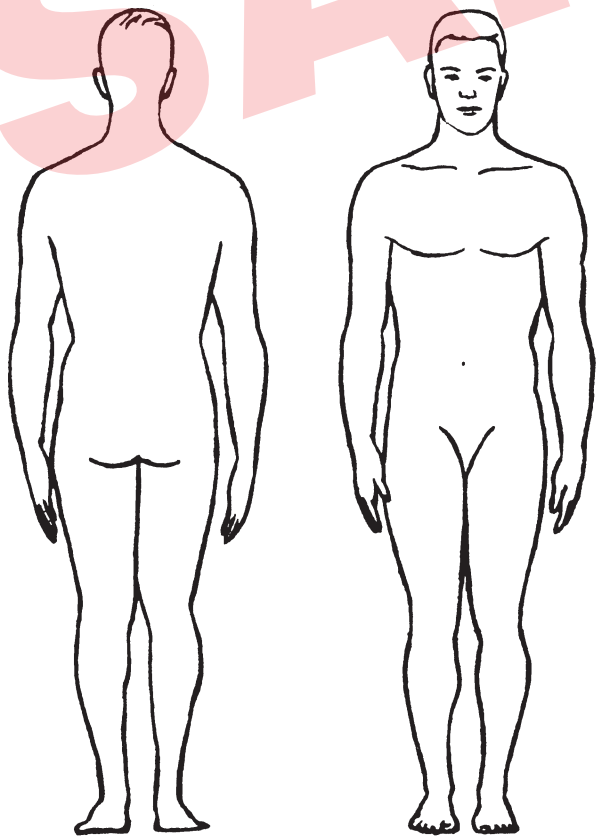
Referred by _____

1. How long have you had this present pain? _____ Hours _____ Days _____ Weeks _____ Months
2. Where were you when this condition started? ☐ At work ☐ At home ☐ Auto accident ☐ Other _____
3. Did your pain begin gradually? ☐ Yes ☐ No Suddenly? ☐ Yes ☐ No Date _____ Time _____
4. Is your pain ☐ Continuous? ☐ Off and on? ☐ Getting progressively worse?
5. Have you had this or similar condition before? ☐ Yes ☐ No If yes, when? _____
6. How long have you been off work or unable to do normal housework? _____
7. Have you ever been in the hospital for ☐ Back ☐ Neck ☐ Leg problems? When? _____
8. Have you ever had back or neck surgery? ☐ Yes ☐ No If yes, when? _____
9. Have other doctors treated you for this condition? ☐ Yes ☐ No If yes, when? _____

   Names of doctors _____ Results _____
10. Have any treatments made your pain worse? ☐ Yes ☐ No What treatments? _____

MARK THE AREAS ON THE FIGURES BELOW WHERE YOU FEEL THE DESCRIBED SENSATIONS WITH THE APPROPRIATE SYMBOLS:

NUMBNESS PINS & NEEDLES BURNING STABBING



MY PAIN IS BETTER	WORSE	UNCHANGED	
☐	☐	☐	With coughing or sneezing
☐	☐	☐	Sitting down at table
☐	☐	☐	Sitting in an automobile
☐	☐	☐	Bending forward to brush teeth
☐	☐	☐	Walking a short distance
☐	☐	☐	Lying flat on back
☐	☐	☐	Lying on side with knees bent
☐	☐	☐	When I wake in the morning
☐	☐	☐	Mid morning
☐	☐	☐	Middle of the night

My back sometimes gets "stuck" when I bend forward ☐ Yes ☐ No
My back feels it is likely to give way on bending forward ☐ Yes ☐ No
My pain stops after I walk a certain distance ☐ Yes ☐ No
After walking, bending forward improves my pain ☐ Yes ☐ No

Date: _____

Signature: _____

PLEASE FILL OUT THE OTHER SIDE IF YOU WERE INVOLVED IN AN AUTO ACCIDENT OR ON THE JOB INJURY/ILLNESS.

#1008
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ACCIDENTAL INJURY

Date of Accident _____ Hour _____ A.M. _____ P.M. Location _____

How did accident occur? ☐ Auto collision ☐ On the job injury/illness ☐ Other _____

Did you report the injury/illness to your employer? ☐ Yes ☐ No Did they recommend care at our office? ☐ Yes ☐ No

If Auto Accident, were you ☐ Driver ☐ Passenger ☐ Pedestrian Did your car strike the other(s) involved? ☐ Yes ☐ No

If Auto Accident, were you struck from ☐ Behind ☐ Right side ☐ Left side ☐ Front ☐ Auto was parked

Did the other car strike yours? ☐ Yes ☐ No ☐ Undetermined

Did the driver of the other car receive traffic citations? ☐ Yes ☐ No The driver of your car? ☐ Yes ☐ No

Were you unconscious? ☐ Yes ☐ No Did you receive ☐ Fractures? ☐ Cuts? ☐ Abrasions? ☐ Bruises?

Did you require post-accident hospitalization? ☐ Yes ☐ No Confined to hospital _____ Hours _____ Days _____ Weeks

List the extent of the injuries as you know them _____

CHECK THE SYMPTOMS BELOW THAT YOU HAVE NOTICED SINCE THE ACCIDENT:

☐ Headache	☐ Dizziness	☐ Light Bothers Eyes	☐ Diarrhea
☐ Neck Pain	☐ Head seems too heavy	☐ Loss of Memory	☐ Feet Cold
☐ Neck Stiff	☐ Pins & Needles in Arms	☐ Ears Ring	☐ Hands Cold
☐ Sleeping Problems	☐ Pins & Needles in Legs	☐ Face Flushed	☐ Stomach Upset
☐ Back Pain	☐ Numbness in Fingers	☐ Buzzing in Ears	☐ Constipation
☐ Nervousness	☐ Numbness in Toes	☐ Loss of Balance	☐ Cold Sweats
☐ Tension	☐ Shortness of Breath	☐ Fainting	☐ Fever
☐ Irritability	☐ Fatigue	☐ Loss of Smell	☐ _____
☐ Chest Pain	☐ Depression	☐ Loss of Taste	☐ _____

Symptoms other than above _____

Have you lost any days of work? ☐ Yes ☐ No Dates _____

Name of other party involved in accident _____

Name of their insurance company _____ Agent _____

Address _____ City _____ State _____

Do you have any group, union or personal health and accident insurance? ☐ Yes ☐ No

Name of your insurance company _____ Claim No. _____

Address _____ City _____ State _____

Have you been contacted by an insurance adjuster or insurance company representative? ☐ Yes ☐ No

Do you have an attorney who has advised you in this case? ☐ Yes ☐ No

If so, Name of attorney _____ Phone _____

Address _____ City _____ State _____

To the best of my knowledge the above information is complete and true.

Signature _____ Date _____