

Patient Basic Information

Personal Information:

Last Name:		First Name:	Mid. Init.:
Address:		City, State, Zip:	
Home Phone:	Work Phone:	Social Security No.:	
Date of Birth:		Date of Injury/Onset:	
Dominant Hand: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both			
Insurance Information: Policy Holder (if different than patient):			Policy No.:

Special Note: If your injury involved a motor vehicle, skip to page 2. Otherwise, use the spaces below to fully describe your accident, injury or onset, slip and fall, etc.

1. Description of Accident/Injury/Onset

Enter a full description of the accident, injury or onset in the space below.

2. Your condition during and immediately after injury/onset

Enter the details of your condition during and immediately after your injury/onset.

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type

Car Station Wagon
 Van Pickup Truck
 Large Truck Bus
 Other _____

2. Your position in vehicle

Driver Front Passenger
 Left Rear Passenger
 Right Rear Passenger
 Other _____

3. What was your vehicle doing at the time of the accident?

Stopped at intersection Stopped in traffic Stopped at light
 Making a right turn Making a left turn Parking
 Proceeding along Slowing down Accelerating
 Other _____

4. Time/Speed/Damage

Time of accident _____
 Your vehicle's speed: _____ mph
 Their vehicle's speed: _____ mph
Damage to your vehicle
 Mild Moderate
 Totaled

5. Details of Accident

Visibility at time of accident
 Poor Fair Good
Who hit who/what?
 You hit other vehicle
 Other vehicle hit you
You hit...(object)

6. Road conditions

Road conditions at time of accident
 Icy Wet Sandy Dark Clean and dry
Point of impact
 Head-On Left Front Right Front
 Read-End Left Rear Right Rear

7. Body Position, etc.

Did you see the accident coming? Yes No
 Were you braced for the impact? Yes No
 Did you have a seat belt on? Yes No
 Did you have a shoulder harness on? Yes No

Does your vehicle have headrests? Yes No
What was the position of your headrest at the time of the impact?
 Even with top of head Even with bottom of head Middle of neck
What was the direction of your head at the time of the impact?
 Facing straight forward Turned to the right Turned to the left

Did driver side air bags deploy? Yes No Did passenger side airbags deploy? Yes No Did side airbags deploy? Yes No

8. Additional accident information

In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

9. During the accident:

Did your body strike the inside of your vehicle? Yes No
 If yes, describe: _____
 Did you lose consciousness during the injury? Yes No
 If yes, for how long? _____
 Your vehicle's estimated damage? _____
Damage to their vehicle: Mild Moderate Totaled
 Did police show up at the scene? Yes No
 Was an accident report filled out? Yes No

10. After the accident:

Check off your symptoms right after and a few days following:
 Headache Dizziness Mid back pain Cold hands
 Neck pain Nausea Low back pain Cold feet
 Neck stiffness Confusion Nervousness Diarrhea
 Fainting Fatigue Loss of taste Depression
 Ringing in ears Tension Toe numbness Anxious
 Loss of smell Irritability Constipation Chest Pain
 Pain behind eyes Shortness of breath Sleeping problems
 Others: _____

11. Emergency Room?

Where did you go after the accident?
 Home Work Hospital ER Private Doctor
How did you get there?
 Drove self Somebody else Ambulance Police
Were X-rays done? Yes No **Was lab work done?** Yes No
 Body parts X-rayed? _____
 What lab work? _____
 The X-rays revealed: _____
Treatments: Cervical Collar Ice **Other:** _____
 Medications: _____
 Follow-up instructions: _____

12. Treatment History:

Fill in any other doctor(s) seen prior to your first visit to this office.
1. Dr. _____ First visit date: ____/____/____
 Specialty: _____ X-rays done? Yes No
 Types of treatments received: _____
 How many treatments received? ____ Currently treating? Yes No
 Did treatments benefit you? Yes No
 Last visit date: ____/____/____
2. Dr. _____ First visit date: ____/____/____
 Types of treatments received: _____
 How many treatments received? ____ Currently treating: Yes No
 Did treatments benefit you? Yes No
 Last visit date: ____/____/____

Description of Symptoms (Describe your symptoms in the sections below, in the order of severity, if possible.)

I. First Current Symptom: (Please check off the boxes below to describe your first symptom. Describe only ONE symptom per Section)

<p>1. Check only one body location below</p> <p><input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Front of Head</p> <p><input type="checkbox"/> Top of Head</p> <p><input type="checkbox"/> Back of Head</p> <p><input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p>Other locations: _____</p>	<p>2. 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II. Second Current Symptom: (Please check off the boxes below to describe your next symptom).

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III. Third Current Symptom: (Please check off the boxes below to describe your 3rd symptom).

<p>1. Check only one body location below</p> <p><input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Front of Head</p> <p><input type="checkbox"/> Top of Head</p> <p><input type="checkbox"/> Back of Head</p> <p><input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p>Other locations: _____</p>	<p>2. 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Description of Symptoms

(Describe your symptoms in the sections below, in the order of severity, if possible.)

IV. Fourth Symptom: (Please check off the boxes below to describe your 4th symptom. Describe only ONE symptom per Section.)																																																															
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VI. Sixth Current Symptom: (Please check off the boxes below to describe your 6th symptom).																																																															
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Description of Symptoms

(Describe your symptoms in the sections below, in the order of severity, if possible.)

VII. Seventh Symptom: (Please check off the boxes below to describe your 7th symptom. Describe only ONE symptom per Section.)

<p>1. Check only one body location below</p> <p><input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p style="padding-left: 20px;"><input type="checkbox"/> Front of Head</p> <p style="padding-left: 20px;"><input type="checkbox"/> Top of Head</p> <p style="padding-left: 20px;"><input type="checkbox"/> Back of Head</p> <p><input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p>Other locations: _____</p>	<p>2. Types of pain</p> <p><input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Aching <input type="checkbox"/> Cutting</p> <p><input type="checkbox"/> Throbbing <input type="checkbox"/> Burning <input type="checkbox"/> Numbing <input type="checkbox"/> Tingling <input type="checkbox"/> Cramping</p> <p><input type="checkbox"/> Spasm <input type="checkbox"/> Stinging <input type="checkbox"/> Shooting <input type="checkbox"/> Pounding <input type="checkbox"/> Constricting</p> <p style="text-align: right;">Other types of pain: _____</p>	<p>3. Pain Frequency</p> <p><input type="checkbox"/> Up to 1/4 of awake time <input type="checkbox"/> 1/4 to 1/2 of time</p> <p><input type="checkbox"/> 1/2 to 3/4 of awake time <input type="checkbox"/> Most all the time</p>	<p>6. Actions affecting this pain</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">Brings On</td> <td style="text-align: center;">Aggravates</td> <td style="text-align: center;">Relieves</td> </tr> <tr> <td><input type="checkbox"/> In the A.M.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> In the P.M.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Bending forward</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input 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Other Actions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<p>4. Pain Intensity (How it affects your daily activities)</p> <p><input type="checkbox"/> Doesn't affect <input type="checkbox"/> Somewhat affects</p> <p><input type="checkbox"/> Seriously affects <input type="checkbox"/> Prevents activities</p>	<p>5. Does this pain radiate into other body parts?</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">Left</td> <td style="text-align: center;">Right</td> <td style="text-align: center;">Both</td> </tr> <tr> <td><input type="checkbox"/> Head</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Neck</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Arm</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Hand</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Hip</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Leg</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Foot</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <p>Other locations of radiation: _____</p>		Left	Right	Both	<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																														
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VIII. Eighth Current Symptom: (Please check off the boxes below to describe your 8th symptom).

<p>1. Check only one body location below</p> <p><input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p style="padding-left: 20px;"><input type="checkbox"/> Front of Head</p> <p style="padding-left: 20px;"><input type="checkbox"/> Top of Head</p> <p style="padding-left: 20px;"><input type="checkbox"/> Back of Head</p> <p><input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p>Other locations: _____</p>	<p>2. Types of pain</p> <p><input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Aching <input type="checkbox"/> Cutting</p> <p><input type="checkbox"/> Throbbing <input type="checkbox"/> Burning <input type="checkbox"/> Numbing <input type="checkbox"/> Tingling <input type="checkbox"/> Cramping</p> <p><input type="checkbox"/> Spasm <input type="checkbox"/> Stinging <input type="checkbox"/> Shooting <input type="checkbox"/> Pounding <input type="checkbox"/> Constricting</p> <p style="text-align: right;">Other types of pain: _____</p>	<p>3. Pain Frequency</p> <p><input type="checkbox"/> Up to 1/4 of awake time <input type="checkbox"/> 1/4 to 1/2 of time</p> <p><input type="checkbox"/> 1/2 to 3/4 of awake time <input type="checkbox"/> Most all the time</p>	<p>6. 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IX. Ninth Current Symptom: (Please check off the boxes below to describe your 9th symptom).

<p>1. Check only one body location below</p> <p><input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p style="padding-left: 20px;"><input type="checkbox"/> Front of Head</p> <p style="padding-left: 20px;"><input type="checkbox"/> Top of Head</p> <p style="padding-left: 20px;"><input type="checkbox"/> Back of Head</p> <p><input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p>Other locations: _____</p>	<p>2. Types of pain</p> <p><input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Aching <input type="checkbox"/> Cutting</p> <p><input type="checkbox"/> Throbbing <input type="checkbox"/> Burning <input type="checkbox"/> Numbing <input type="checkbox"/> Tingling <input type="checkbox"/> Cramping</p> <p><input type="checkbox"/> Spasm <input type="checkbox"/> Stinging <input type="checkbox"/> Shooting <input type="checkbox"/> Pounding <input type="checkbox"/> Constricting</p> <p style="text-align: right;">Other types of pain: _____</p>	<p>3. Pain Frequency</p> <p><input type="checkbox"/> Up to 1/4 of awake time <input type="checkbox"/> 1/4 to 1/2 of time</p> <p><input type="checkbox"/> 1/2 to 3/4 of awake time <input type="checkbox"/> Most all the time</p>	<p>6. 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Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty: **1** = "I can do it without any difficulty", **2** = "I can do it without much difficulty, despite some pain", **3** = "I manage to do it by myself, despite marked pain", **4** = "I manage to do it, despite the pain, but only if I have help", **5** = "I cannot do it at all, because of the pain". **NOTE: Only fill in areas that are affected.**

Difficulties with Self Care and Personal Hygiene Activities

Bathing ___ Drying hair ___ Brushing teeth ___ Putting on shoes ___ Preparing meals ___ Taking out trash .. ___
 Showering ___ Combing hair ___ Making bed ___ Tying shoes ___ Eating ___ Doing laundry ___
 Washing hair .. ___ Washing face ___ Putting on shirt ___ Putting on pants ___ Cleaning dishes ___ Going to toilet ___

Difficulties with Physical Activities

Standing ___ Walking ___ Kneeling ___ Bending back ___ Twisting left ___ Leaning back ___
 Sitting ___ Stooping ___ Reaching ___ Bending left ___ Twisting right ___ Leaning left ___
 Reclining ___ Squatting ___ Bending forward .. ___ Bending right ___ Leaning forward ___ Leaning right ___
 Standing for long periods ___ Sitting for long periods..... ___ Walking for long periods..... ___ Kneeling for long periods ___

Difficulties with Functional Activities

Carrying small objects ___ Lifting weights off floor ___ Pushing things while seated ___ Exercising upper body ___
 Carrying large objects ___ Lifting weights off table ___ Pushing things while standing .. ___ Exercising lower body ___
 Carrying brief case ___ Climbing stairs ___ Pulling things while seated ___ Exercising arms ___
 Carrying large purse ___ Climbing inclines ___ Pulling things while standing ___ Exercising legs ___

Difficulties with Social and Recreational Activities

Bowling ___ Jogging ___ Swimming ___ Ice Skating ___ Competitive Sports . ___ Dating ___
 Golfing ___ Dancing ___ Skiing ___ Roller Skating ___ Hobbies ___ Dining out ___

Difficulties with Travelling

Driving a motor vehicle ___ Riding as a passenger in a motor vehicle ___ Riding as a passenger on a train ___
 Driving for long periods of time ___ Riding as a passenger on an airplane ___ Riding as a passenger for long periods ___

Use the following **1 to 5** scale to describe the difficulties below:

1 = "This area is not affected by my condition", **2** = "This area is slightly affected by my condition", **3** = "My condition moderately restricts my ability in this area", **4** = " My condition seriously limits my ability in this area", **5** = "My condition prevents me from using this ability"

Difficulties with Different Forms of Communication

Concentrating.... ___ Hearing.... ___ Listening.... ___ Speaking.... ___ Reading.... ___ Writing.... ___ Using a keyboard.... ___

Difficulties with the Senses

Seeing..... ___ Hearing..... ___ Sense of touch..... ___ Sense of taste..... ___ Sense of smell..... ___

Difficulties with Hand Functions

Grasping..... ___ Holding..... ___ Pinching..... ___ Percussive movements..... ___ Sensory discrimination..... ___

Difficulties with Sleep and Sexual Function

Being able to have normal, restful nights sleep..... ___ Being able to participate in desired sexual activity..... ___

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

Prior Symptom History

Prior Similar Symptoms

- I have NOT had prior symptoms similar to my current complaints.
- My current complaints DID exist before, but have not been bothering me.
- My current complaints ALREADY existed and were worsened.

Has your History Contributed to your Current Symptoms?

- My history HAS contributed to my current symptoms.
- My history HAS NOT contributed to my current symptoms.
- I'm NOT SURE if my history has contributed to my current symptoms.

My most recent prior similar symptoms (if applicable) occurred..... ___ months ago / years ago **Or on** Date: ___/___/___

Write in below any other Prior Symptom History, not covered above: