PATIENT ACCIDENT / INJURY / MEDICAL HISTORY FORM

Name _____ Today's Date _____

Date of Injury / Accident _____

Vehicles Involved:

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 $_____

Describe Accident: _____
_____
_____

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

Job or Work Related Injury: [ ] YES [ ] NO

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
[ ] Broken glass

Did you experience: [ ] Shock [ ] Loss of Consciousness
[ ] Flash of light seen upon impact

Air bag deployed [ ]

State your Emotions and Physical State *Immediately Following* the accident: _____
_____

The road was: [ ] Dry [ ] Wet [ ] Icy [ ] Snowy

The weather conditions were: [ ] Sunny [ ] Cloudy [ ] Foggy
[ ] Light rain [ ] Heavy rain [ ] Snowing

Time of day: [ ] Dawn [ ] Day [ ] Dusk [ ] Night [ ] Unknown

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

Symptomatology (Pain characteristics for major area of complaint):

The pain started _____

The pain is made better by _____

And 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 parasthesia (tingling/numbness) into _____

The pain is located _____

The pain is (as far as timing is concerned: i.e. comes & goes, constant, etc.)_____

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 doe the following activities affect your pain?

	No Change	Relieves	Increased	Duration
Sitting	[ ]	[ ]	[ ]	[ ]
Walking	[ ]	[ ]	[ ]	[ ]
Standing	[ ]	[ ]	[ ]	[ ]
Lying Down	[ ]	[ ]	[ ]	[ ]
Looking Up	[ ]	[ ]	[ ]	[ ]
Looking Down	[ ]	[ ]	[ ]	[ ]
Lifting	[ ]	[ ]	[ ]	[ ]

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.

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-have trouble coping with it

Progression
How is your pain compared to when the pain episode first started?
[ ] Much improved
[ ] A little worse
[ ] Somewhat improved
[ ] Much worse
[ ] No change

What are some recreational activities that you participated in before this problem and which ones cannot be performed now to the same extent as before?

[ ] 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 tot 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.
[ ] 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.

How often to 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

SOCIAL HISTORY

[ ] Single
[ ] Married
[ ] Divorced
# of Children:_____

[ ] Smoker
[ ] Non-smoker
[ ] Drinks alcohol
[ ] Does not drink alcohol
[ ] Takes drugs
[ ] Does not take drugs

List Your Hobbies

OCCUPATIONAL HISTORY

Your Employer_____

Job Title_____

What is your current job satisfaction:
[ ] Very satisfied
[ ] Satisfied
[ ] Dissatisfied
[ ] Very dissatisfied

Are your job duties physically demanding for you? [ ] Yes [ ] No

Have had any disability time? [ ] Yes [ ] No

If you are currently working which are you performing?
[ ] Regular duties
[ ] Limited – Light duties

Your highest level of education attained?

MEDICAL HISTORY

List the physicians and other practitioners you have seen for Your problem:

List the medications you are currently taking:

List the treatments you have had for your problem:
[ ] Hot packs / ultrasound
[ ] Massage
[ ] Electrical Stimulation
[ ] TENS Unit
[ ] Chiropractic
[ ] Osteopathy
[ ] Biofeedback
[ ] Trigger Point Injections

List the types of diagnostic Testing that has been performed for this problem:
[ ] X-rays
[ ] CT scan
[ ] Myelogram
[ ] Discogram
[ ] Bone scan
[ ] EMG

[ ] Body mechanics training [ ] Epidural Injections [ ] MRI scan
[ ] Strengthening exercises [ ] Back brace
[ ] Aerobics [ ] Acupuncture
[ ] Gravity inversion-traction [ ] Naturopathy
[ ] Bed rest

List past surgeries: [ ] None

_____
_____
_____

List past hospitalizations: [ ] None

_____
_____
_____

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

_____
_____
_____
_____
_____
_____
_____

Mark below 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 any problems with:
[ ] Anxiety
[ ] Depression
[ ] Irritability

Do you have a home exercise program that you follow on a regular basis?
[ ] Yes [ ] No

Females only – Mark if you 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