

**CONFIDENTIAL HISTORY**

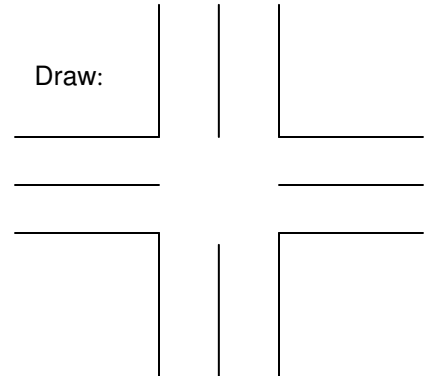
Date: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
First: \_\_\_\_\_ Last: \_\_\_\_\_ M.I. \_\_\_\_\_ SSN: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone #: \_\_\_\_\_  
City: \_\_\_\_\_ ZIP: \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
E-mail: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_  
Check if you are:  Married  Single  Widowed  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Referred by: \_\_\_\_\_ Dates of Worked Missed due to Injury: \_\_\_\_\_

**NATURE OF MVA**

Date & Time of Motor Vehicle Collision: \_\_\_\_\_ Road conditions:  Dry  Wet  Icy  
Was a police report made?  Yes  No Do you have a copy of the report?  Yes  No  
Did you go to the hospital?  Yes  No How did you get there? \_\_\_\_\_  
How long did you stay? \_\_\_\_\_ What areas were x-rayed?  Low Back  Neck  Other  
What was your diagnosis? \_\_\_\_\_  
What treatments were given? \_\_\_\_\_

Please describe the Motor Vehicle Collision to the best of your knowledge.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Where were you seated in the vehicle? \_\_\_\_\_ How many people in vehicle? \_\_\_\_\_  
Were you aware of the pending collision?  Yes  No Did you tense up?  Yes  No  
Were you in a (car) (truck) (other)? Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_  
Where was your vehicle damaged? \_\_\_\_\_ What was the estimated damage cost? \$ \_\_\_\_\_  
Did you receive any injury, bruise, or pain from the seat belt?  Yes  No  Not Buckled  
What direction were you looking? \_\_\_\_\_ Was your foot on the brake?  Yes  No

**CURRENT CONDITIONS**

Did you have pain immediately?  Yes  No  
Please describe when you first experienced pain: \_\_\_\_\_

List & Describe Present Complaints / Conditions in order of Importance (please be specific):  
*Example: Pain in lower back on right side that goes down the back of right leg to the knee. Worse when bending.*  
• \_\_\_\_\_  
• \_\_\_\_\_  
• \_\_\_\_\_  
• \_\_\_\_\_

Have you had this or a similar condition in the past?  Yes  No Explain: \_\_\_\_\_

What treatments have you received for these conditions:  Medication  Surgery  Physical Therapy  Chiropractic  
 None  Other \_\_\_\_\_

### EXPERIENCE WITH CHIROPRACTIC

Have you seen a chiropractor before:  Yes  No

If yes, who? \_\_\_\_\_ When? \_\_\_\_\_

Reason for visits: \_\_\_\_\_ How did you respond? \_\_\_\_\_

Length of treatment: \_\_\_\_\_ X-Rays taken? \_\_\_\_\_

### PERSONAL MEDICAL HISTORY

Have you been treated for any health condition by a Physician in the last year?  Yes  No

If so, what Doctor, and why? \_\_\_\_\_

List the approximate dates of any surgeries, serious illnesses, accidents, or unusual diseases you have had:

Joint Replacement(s) / Date(s): \_\_\_\_\_

List all medication(s) that you have used recently (i.e., aspirin, sleeping pills, anti-depressants): \_\_\_\_\_

Has medication been helpful with your pain?  Yes  No

Date of last: Spinal X-ray: \_\_\_\_\_ Physical Exam: \_\_\_\_\_ Blood / Urine Test: \_\_\_\_\_

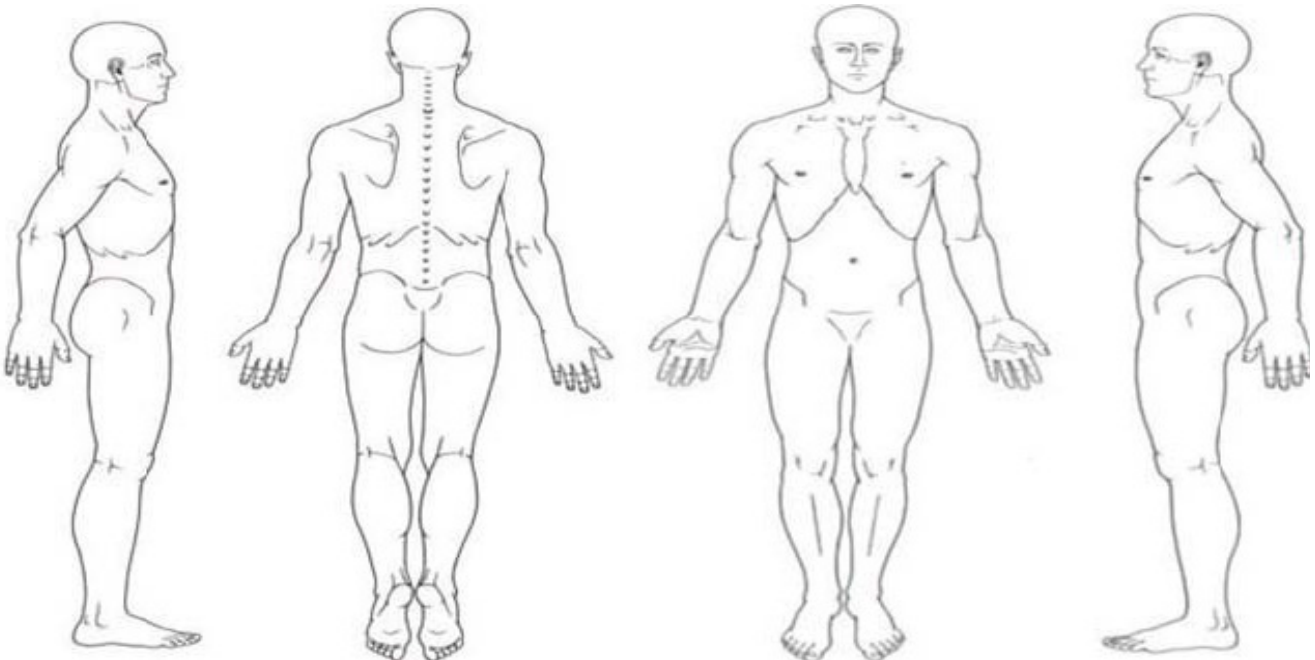
List all nutritional and/or vitamin supplements taken regularly:  Multivitamin  Fish Oil  Probiotic  VitaminD

Others: \_\_\_\_\_

Do you exercise?  Yes  No What Activities? \_\_\_\_\_ How often? \_\_\_\_\_

Please mark **ALL areas** of pain or numbness/tingling on the figures below:

**Include:**  Head  Neck  Chest  Back  Arms  Hands  Legs



Type of Pain:

- |                                   |                                    |                                     |
|-----------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Local    | <input type="checkbox"/> Traveling | <input type="checkbox"/> Achy       |
| <input type="checkbox"/> Sharp    | <input type="checkbox"/> Dull      | <input type="checkbox"/> "Electric" |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Numb      |                                     |

What is your TYPICAL or AVERAGE pain?

No pain \_\_\_\_\_ worst possible pain  
 0 1 2 3 4 5 6 7 8 9 10

What is your level of pain AT ITS WORST?

No pain \_\_\_\_\_ worst possible pain  
 0 1 2 3 4 5 6 7 8 9 10

How often do you experience your symptoms?

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)

How are your symptoms changing?

- Getting Better
- Not Changing
- Getting Worse

When do you notice them most?

- Morning
- Afternoon
- Evening
- In Bed

Which of the following cause pain or are difficult?

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	0	0	0	0	Household Chores	0	0	0	0
Stand from Chair	0	0	0	0	Lifting Objects	0	0	0	0
Standing	0	0	0	0	Reaching Overhead	0	0	0	0
Walking	0	0	0	0	Dressing Myself	0	0	0	0
Lying Down	0	0	0	0	Getting to Sleep	0	0	0	0
Bending Over	0	0	0	0	Staying Asleep	0	0	0	0
Climbing Stairs	0	0	0	0	Concentrating	0	0	0	0
Computer Use	0	0	0	0	Exercising	0	0	0	0
Driving a Car	0	0	0	0	Yard Work	0	0	0	0
Caring for Family	0	0	0	0	_____	0	0	0	0
					(other)				

For each of the conditions listed below, place a check in the past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the present column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Prod.
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependency
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip/Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Knee/Lower Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss	<b>Females Only</b>	
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Joint Swelling/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<b>Other Health Problems/Issues</b>	
<input type="checkbox"/>	<input type="checkbox"/> General Fatigue	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbance	<input type="checkbox"/>	<input type="checkbox"/> Asthma		
<input type="checkbox"/>	<input type="checkbox"/> Dizziness	<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis		