PATIENT INJURY/MEDICAL HISTORY FORM

Name _____ **Date** _____

Date of Loss/Onset (Accident): _____ **Claim Number:** _____

Describe Accident:

_____

_____

_____

Specifics of Accident (Mark each that applies to the accident):
Job or Work Related injury ( ) Yes ( ) No

Your were the [ ] Driver [ ] Passenger
Sitting [ ] Front seat [ ] Back seat

Impending Collision [ ] Braced [ ] Not braced
Head Did [ ] Strike Object [ ] Not strike Object
Did you experience [ ] Shock
[ ] Flash of Light Seen Upon Impact
[ ] Air bag Deployed

Immediately Following the Accident

[ ] Ambulance – Paramedics Called
[ ] Treated at Scene
[ ] Transported to Hospital by Ambulance
[ ] Went to Hospital on his/her Own
[ ] Diagnostics Preformed at Hospital
[ ] Medication Prescribed
[ ] Treatment at Hospital
[ ] Follow-up Recommended

Time Loss

[ ] NO time loss from work due to injury. I am currently working with No limitations.
[ ] NO time loss form work due to injury BUT I do have limitations*.
[ ] I have experienced time loss from work due to injury. Indicate number of days____, weeks____, months_____ etc
[ ] N/A

Additional Comments:

_____

_____

****

Mechanism of Injury

Were you surprised by the impact? __Yes __No

In relation to the back of your head, was your headrest set: __Low __Middle __High __None

Where was your head facing at the time of impact? __Left __Forward __Right __Unknown

Were you leaning forward at the time of impact? __Yes __No

Were you wearing a seatbelt/harness? __Yes __No

Were you rendered unconscious as a result of the accident? __Yes __No

Did you feel pain immediately after the accident? __Yes __No

Year and type of vehicle were you in? _____

Size of your vehicle? __Small __Mid __Large __Unknown

Year and type of other vehicle involved in the accident? _____

Size of other vehicle? __Small __Mid __Large __Unknown

What was the approximate speed of your vehicle when the accident occurred? _____

What was the approximate speed of the other vehicle when the accident occurred? _____

Patient's Name: _____ Date: _____

PAIN FORM

Symptomatology Consultation Form

Pain Intensity:

Intensity scale:
0 = No pain
1 – 3 = Mild Nuisance
4 – 5 = Mild to Moderate Nuisance
6 - 7 = Moderate, having trouble dealing with it
8 -10 = Severe, it is affecting patient's quality of life

WHERE DID YOU HURT BEFORE THE ACCIDENT

Symptoms prior to most recent motor vehicle collision:

Headaches:	exactly where/site _____	intensity____	frequency of awake time _____
Jaw Pain:	exactly where/site _____	intensity____	frequency of awake time _____
Neck Pain:	exactly where/site _____	intensity____	frequency of awake time _____
Middle Back Pain:	exactly where/site _____	intensity____	frequency of awake time _____
Low Back Pain:	exactly where/site _____	intensity____	frequency of awake time _____
Other:	exactly where/site _____	intensity____	frequency of awake time _____
Other:	exactly where/site _____	intensity____	frequency of awake time _____
Other:	exactly where/site _____	intensity____	frequency of awake time _____

WHERE DID YOU HURT IMMEDIATELY AFTER THE ACCIDENT

Original symptoms from most recent motor vehicle collision:

Headaches:	exactly where/site _____	intensity____	frequency of awake time _____
Jaw Pain:	exactly where/site _____	intensity____	frequency of awake time _____
Neck Pain:	exactly where/site _____	intensity____	frequency of awake time _____
Middle Back Pain:	exactly where/site _____	intensity____	frequency of awake time _____
Low Back Pain:	exactly where/site _____	intensity____	frequency of awake time _____
Other:	exactly where/site _____	intensity____	frequency of awake time _____
Other:	exactly where/site _____	intensity____	frequency of awake time _____
Other:	exactly where/site _____	intensity____	frequency of awake time _____

WHERE ARE YOU HURTING TODAY

Presenting/Current Symptoms:

Headaches:	exactly where/site _____	intensity____	frequency of awake time _____
Jaw Pain:	exactly where/site _____	intensity____	frequency of awake time _____
Neck Pain:	exactly where/site _____	intensity____	frequency of awake time _____
Middle Back Pain:	exactly where/site _____	intensity____	frequency of awake time _____
Low Back Pain:	exactly where/site _____	intensity____	frequency of awake time _____
Other:	exactly where/site _____	intensity____	frequency of awake time _____
Other:	exactly where/site _____	intensity____	frequency of awake time _____
Other:	exactly where/site _____	intensity____	frequency of awake time _____

What makes current pain worse:

Describe directly below for example (bending, sitting)	Achy	Burning	Dull	Sharp	Throb	Other	Worse in AM**or**PM	
Headaches:								
Jaw Pain:								
Neck Pain:								
Middle Back Pain:								
Low Back Pain:								
Other:								
Other:								
Other:								

What makes current pain better:

Headaches:
Jaw Pain:
Neck Pain:
Middle Back Pain:
Low Back Pain:
Other:
Other:
Other:

Further Pain information:

Radiating Pain/Numbness/Tingling/Burning/Weakness ____Yes ___No

Location _____

****

Social History

List your Hobbies & Exercise Activities_____

_____

_____

_____

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

[ ] Smoker
[ ] Non-Smoker
[ ] Drinks Alcohol
[ ] Does not drink Alcohol
[ ] Takes Drugs
[ ] Does not take Drugs

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 you 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?_____

****

Name _____ **Date** _____

Medical History Form 1

I have seen the following physician/practitioners for this condition:
Chiropractor (Name): _____
Massage Therapist: _____
Neurologist: _____
Orthopedist: _____
Physical Therapist: _____
Physician: _____
Psychiatrist/Psychologist: _____
Other: _____

Do you feel you are troubled with:
[ ] Anxiety
[ ] depression
[ ] irritability

Current medications I am taking:
_____
_____
_____
_____

List the treatments you have had for this condition.
[ ] Ice
[ ] Heat/Ultrasound
[ ] Electrical Stimulation
[ ] Chiropractic
[ ] Osteopathy
[ ] Injections
_____
[ ] Exercises
[ ] Gravity Inversion – Traction
[ ] Bed Rest
[ ] Acupuncture
[ ] Naturopathy
[ ] Massage

Past Surgeries:
_____
_____
_____

Past Hospitalizations:

_____

List previous back, neck and musculoskeletal problems:

****

Name _____ **Date** _____

PATIENT INJURY/MEDICAL HISTORY FORM 2

List the types of Diagnostic Testing that has been for this condition:
[ ] X-rays
[ ] CT Scan
[ ] Myelogram
[ ] MRI
[ ] Discogram
[ ] Bone Scan
[ ] EMG

Females – Mark if 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

Name _____ **Date** _____

Mark 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

Make sure to fill out the neck pain disability index questionnaire and/ or Oswestry low back pain questionnaire in addition.