

SpinaCare Chiropractic & Massage Medical History Information

How did you hear about us?

Emergency Contact Name and Number:

Last Name:		Middle:		<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital status (circle one) Single / Mar / Div / Sep / Widow	
First Name:				<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.		
Email:				Birth date:		Age:	Sex:
Address:			City:		State:		
ZIP Code:		Social Security No.:		Home Phone:			
				Cell Phone :			
Occupation:		Employer:			Employer phone:		
Medical Care Information							
Do You Have a Family Doctor?:		<input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Doctor:					
Address:			City:		State:		ZIP Code:
Date of last Visit: / /			Date of last exam: / /				
Do You Have a Family Chiropractor?:		<input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Chiropractor:					
Address:			City:		State:		ZIP Code:
Date of last Visit: / /			Date of last exam: / /				
Have you had surgeries in the last 5 Years:		<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, Last Surgery Date:			
Reason for Surgery:							
Present illness /Conditions:							
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease			
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Epilepsy		
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Tuberculosis		<input type="checkbox"/>	
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Ulcer		<input type="checkbox"/>	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Polio		<input type="checkbox"/>	
<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> STD'S		<input type="checkbox"/>	
Other:							
Family History of illness:							
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease	<input type="checkbox"/> STD'S			
<input type="checkbox"/> Allergies	<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Ulcer		
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Polio		
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Scoliosis		
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diverticulitis		
Are you currently taking any prescription or non-prescription medications?							
Type of Cancer: <input type="checkbox"/> Breast <input type="checkbox"/> Lung <input type="checkbox"/> Other:							

Social History:			
Alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per week?	Cigarettes? <input type="checkbox"/> No <input type="checkbox"/> Yes Packs per day?	Caffeine? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per day?	Exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes Hours per week? (circle one) Light / Moderate / Strenuous

Signature: _____

Date: _____

Patient's Name: _____

Date: _____

VITALS: Weight: _____ Height: _____ Blood Pressure: _____ Pulse: _____

I Am: Right Handed: _____ Left Handed: _____

HISTORY OF INJURY (This will be taken by patient assistant):

HEADACHES	
Location	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center <input type="checkbox"/> Center and to the Left <input type="checkbox"/> Center and to the Right
Pain	<input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Burning
Severity	<input type="checkbox"/> Mild <input type="checkbox"/> Mild to Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate to Severe <input type="checkbox"/> Severe
Pain scale 0 No Pain 10 Excruciating Pain	No Pain 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Excruciating pain Please circle the number or if it is a half please put a line between the numbers
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Specific Site of Pain	<input type="checkbox"/> Forehead <input type="checkbox"/> Behind Eyes <input type="checkbox"/> Back of Skull <input type="checkbox"/> Sides of Head <input type="checkbox"/> Temples <input type="checkbox"/> Throughout Head
Onset?	<input type="checkbox"/> At time of Accident <input type="checkbox"/> After Accident <input type="checkbox"/> Unknown <input type="checkbox"/> Specific Date (please write)
What makes it better?	<input type="checkbox"/> Lying Down <input type="checkbox"/> Motion of Neck <input type="checkbox"/> Medication <input type="checkbox"/> Nothing <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Stretching <input type="checkbox"/> Chiropractic TX <input type="checkbox"/> Heat <input type="checkbox"/> Ice <input type="checkbox"/> Resting <input type="checkbox"/> Other(specify)
What makes it worse?	<input type="checkbox"/> Bright Lights <input type="checkbox"/> House Work <input type="checkbox"/> Load Noises <input type="checkbox"/> Neck Movement <input type="checkbox"/> Reading <input type="checkbox"/> Watching TV <input type="checkbox"/> Working <input type="checkbox"/> Laying to Sitting <input type="checkbox"/> Laying to Standing <input type="checkbox"/> Sitting to Laying <input type="checkbox"/> Sitting to Standing <input type="checkbox"/> Standing to Laying <input type="checkbox"/> Standing to Sitting <input type="checkbox"/> Other(specify)
Quality of the Pain?	<input type="checkbox"/> Ache <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing <input type="checkbox"/> Electric <input type="checkbox"/> Fiery <input type="checkbox"/> Shooting <input type="checkbox"/> Deep <input type="checkbox"/> Superficial <input type="checkbox"/> Other(specify)
Radiating (traveling pain)	<input type="checkbox"/> Neck <input type="checkbox"/> Left Ear <input type="checkbox"/> Left Eye <input type="checkbox"/> Left Jaw <input type="checkbox"/> Right Ear <input type="checkbox"/> Right Eye <input type="checkbox"/> Right Jaw <input type="checkbox"/> Other (specify)
Timing	<input type="checkbox"/> Afternoon <input type="checkbox"/> During Night <input type="checkbox"/> Evening <input type="checkbox"/> During Light Activities <input type="checkbox"/> During Moderate Activities <input type="checkbox"/> Morning <input type="checkbox"/> Constant <input type="checkbox"/> Other (specify):

Side Effects	<input type="checkbox"/> Buzzing in Ears <input type="checkbox"/> Dizziness <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Nausea <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Sensitive to Bright <input type="checkbox"/> Visual Problems <input type="checkbox"/> Other (specify):
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PatientComments: _____

DoctorNotes: _____

NECK	
Location	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center <input type="checkbox"/> Center and to the Left <input type="checkbox"/> Center and to the Right
Pain	<input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Burning
Severity	<input type="checkbox"/> Mild <input type="checkbox"/> Mild to Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate to Severe <input type="checkbox"/> Severe
Pain scale 0 No Pain 10 Excruciating Pain	No Pain 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Excruciating pain Please circle the number or if it is a half please put a line between the numbers
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Onset?	<input type="checkbox"/> At time of Accident <input type="checkbox"/> After Accident <input type="checkbox"/> Unknown <input type="checkbox"/> Specific Date (please write)
What makes it better?	<input type="checkbox"/> Lying Down <input type="checkbox"/> Medication <input type="checkbox"/> Nothing <input type="checkbox"/> Range of Motion <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Stretching <input type="checkbox"/> Chiropractic <input type="checkbox"/> Heat <input type="checkbox"/> Ice <input type="checkbox"/> Resting
What makes it worse?	<input type="checkbox"/> Neck Movement <input type="checkbox"/> Prolonged Sitting <input type="checkbox"/> Prolonged Standing <input type="checkbox"/> Prolonged Walking <input type="checkbox"/> Sneezing <input type="checkbox"/> Daily Activities <input type="checkbox"/> Lateral Bending L <input type="checkbox"/> Lateral Bending R <input type="checkbox"/> Rotation Left <input type="checkbox"/> Rotation R <input type="checkbox"/> Laying to Sit <input type="checkbox"/> Laying to Standing <input type="checkbox"/> Sitting to Laying <input type="checkbox"/> Sit to Standing <input type="checkbox"/> Stand to laying
Quality of the Pain?	<input type="checkbox"/> Ache <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing <input type="checkbox"/> Electric <input type="checkbox"/> Fiery <input type="checkbox"/> Shooting <input type="checkbox"/> Deep <input type="checkbox"/> Superficial <input type="checkbox"/> Other(specify)
Radiating (traveling pain)	<input type="checkbox"/> Back of Head <input type="checkbox"/> Sides of head <input type="checkbox"/> Left Arm <input type="checkbox"/> Left Fingers <input type="checkbox"/> Left forearm <input type="checkbox"/> Left Hand <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Left Shoulder Blade <input type="checkbox"/> Right Arm <input type="checkbox"/> Right Fingers <input type="checkbox"/> Right Forearm <input type="checkbox"/> Right Hand <input type="checkbox"/> Right Shoulder <input type="checkbox"/> Right Shoulder Blade
Timing	<input type="checkbox"/> Afternoon <input type="checkbox"/> During Night <input type="checkbox"/> Evening <input type="checkbox"/> During Light Activities <input type="checkbox"/> During Moderate Activities <input type="checkbox"/> Morning <input type="checkbox"/> Constant <input type="checkbox"/> Other (specify):
Side Effects	<input type="checkbox"/> Decreased Range of Motion <input type="checkbox"/> Increased Sensitivity <input type="checkbox"/> Numbness <input type="checkbox"/> Stiffness <input type="checkbox"/> Tightness <input type="checkbox"/> Tingling <input type="checkbox"/> Other (specify):

PatientComments: _____

DoctorNotes: _____

UPPERBACK

Location	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center <input type="checkbox"/> Center and to the Left <input type="checkbox"/> Center and to the Right
Pain	<input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Burning
Severity	<input type="checkbox"/> Mild <input type="checkbox"/> Mild to Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate to Severe <input type="checkbox"/> Severe
Pain scale 0 No Pain 10 Excruciating Pain	No Pain 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Excruciating pain Please circle the number or if it is a half please put a line between the numbers
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Onset?	<input type="checkbox"/> At time of Accident <input type="checkbox"/> After Accident <input type="checkbox"/> Unknown <input type="checkbox"/> Specific Date (please write)
What makes it better?	<input type="checkbox"/> Lying Down <input type="checkbox"/> Medication <input type="checkbox"/> Nothing <input type="checkbox"/> Range of Motion <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Stretching <input type="checkbox"/> Chiropractic TX <input type="checkbox"/> Heat <input type="checkbox"/> Ice <input type="checkbox"/> Resting <input type="checkbox"/> Laying on Left Side <input type="checkbox"/> Laying on Right Side <input type="checkbox"/> Leaning Left <input type="checkbox"/> Leaning Right <input type="checkbox"/> Other(specify)
What makes it worse?	<input type="checkbox"/> Bending <input type="checkbox"/> Coughing <input type="checkbox"/> House Work <input type="checkbox"/> Prolonged Sitting <input type="checkbox"/> Prolonged Standing <input type="checkbox"/> Prolonged Walking <input type="checkbox"/> Sneezing <input type="checkbox"/> Working <input type="checkbox"/> Activities of Daily living <input type="checkbox"/> Bending Left <input type="checkbox"/> Bending to the Right <input type="checkbox"/> Rotating Left <input type="checkbox"/> Rotating Right <input type="checkbox"/> Laying to sitting <input type="checkbox"/> Laying to Standing <input type="checkbox"/> Sitting to Laying <input type="checkbox"/> Standing to Laying <input type="checkbox"/> Bowel Movements <input type="checkbox"/> Reaching <input type="checkbox"/> Other (specify)
Quality of the Pain?	<input type="checkbox"/> Ache <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing <input type="checkbox"/> Electric <input type="checkbox"/> Fiery <input type="checkbox"/> Shooting <input type="checkbox"/> Deep <input type="checkbox"/> Superficial <input type="checkbox"/> Other(specify)
Radiating (traveling pain)	<input type="checkbox"/> Ribs <input type="checkbox"/> Low back <input type="checkbox"/> Other (specify)
Timing	<input type="checkbox"/> Afternoon <input type="checkbox"/> During Night <input type="checkbox"/> Evening <input type="checkbox"/> During Light Activities <input type="checkbox"/> During Moderate Activities <input type="checkbox"/> Morning <input type="checkbox"/> Constant <input type="checkbox"/> Other (specify):
Side Effects	<input type="checkbox"/> Decreased ROM <input type="checkbox"/> Increased Sensitivity <input type="checkbox"/> Numbness <input type="checkbox"/> Stiffness <input type="checkbox"/> Tightness <input type="checkbox"/> Tingling <input type="checkbox"/> Other (specify):

PatientComments: _____

DoctorNotes: _____

MID BACK

Location	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center <input type="checkbox"/> Center and to the Left <input type="checkbox"/> Center and to the Right
Pain	<input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Burning
Severity	<input type="checkbox"/> Mild <input type="checkbox"/> Mild to Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate to Severe <input type="checkbox"/> Severe
Pain scale 0 No Pain 10 Excruciating Pain	No Pain 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Excruciating pain Please circle the number or if it is a half please put a line between the numbers
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Onset?	<input type="checkbox"/> At time of Accident <input type="checkbox"/> After Accident <input type="checkbox"/> Unknown <input type="checkbox"/> Specific Date (please write)

What makes it better?	<input type="checkbox"/> Lying Down <input type="checkbox"/> Medication <input type="checkbox"/> Nothing <input type="checkbox"/> Motion of Mid back <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Stretching <input type="checkbox"/> Chiropractic TX <input type="checkbox"/> Heat <input type="checkbox"/> Ice <input type="checkbox"/> Resting <input type="checkbox"/> Laying on left side <input type="checkbox"/> Laying on Right Side <input type="checkbox"/> Leaning Left <input type="checkbox"/> Leaning Right <input type="checkbox"/> Other(specify)
What makes it worse?	<input type="checkbox"/> Bending <input type="checkbox"/> House Work <input type="checkbox"/> Lifting <input type="checkbox"/> Prolonged Sitting <input type="checkbox"/> Prolonged Standing <input type="checkbox"/> Prolonged Walking <input type="checkbox"/> Working <input type="checkbox"/> Normal Daily Activities <input type="checkbox"/> Bend to Left <input type="checkbox"/> Bend to Right <input type="checkbox"/> Rotation Left <input type="checkbox"/> Rotation Right <input type="checkbox"/> Laying to Sitting <input type="checkbox"/> Laying to Standing <input type="checkbox"/> Sitting to Laying <input type="checkbox"/> Sitting to Standing <input type="checkbox"/> Standing to Laying <input type="checkbox"/> Standing to Sitting <input type="checkbox"/> Bowel Movements <input type="checkbox"/> Reaching <input type="checkbox"/> Other(specify)
Quality of the Pain?	<input type="checkbox"/> Ache <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing <input type="checkbox"/> Electric <input type="checkbox"/> Fiery <input type="checkbox"/> Shooting <input type="checkbox"/> Deep <input type="checkbox"/> Superficial <input type="checkbox"/> Other(specify)
Radiating (traveling pain)	<input type="checkbox"/> Left Ribs <input type="checkbox"/> Lower Back <input type="checkbox"/> Neck <input type="checkbox"/> Right Ribs <input type="checkbox"/> Other (specify)
Timing	<input type="checkbox"/> Afternoon <input type="checkbox"/> During Night <input type="checkbox"/> Evening <input type="checkbox"/> During Light Activities <input type="checkbox"/> During Moderate Activities <input type="checkbox"/> Morning <input type="checkbox"/> Constant <input type="checkbox"/> Other (specify):
Side Effects	<input type="checkbox"/> Decreased Motion <input type="checkbox"/> Increased Sensitivity <input type="checkbox"/> Numbness <input type="checkbox"/> Tightness <input type="checkbox"/> Tingling <input type="checkbox"/> Stiffness <input type="checkbox"/> Other (specify):

PatientComments: _____

DoctorNotes: _____

LOW BACK	
Location	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center <input type="checkbox"/> Center and to the Left <input type="checkbox"/> Center and to the Right
Pain	<input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Burning
Severity	<input type="checkbox"/> Mild <input type="checkbox"/> Mild to Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate to Severe <input type="checkbox"/> Severe
Pain scale 0 No Pain 10 Excruciating Pain	<p>No Pain 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Excruciating pain</p> <p>Please circle the number or if it is a half please put a line between the numbers</p>
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Onset?	<input type="checkbox"/> At time of Accident <input type="checkbox"/> After Accident <input type="checkbox"/> Unknown <input type="checkbox"/> Specific Date (please write)
What makes it better?	<input type="checkbox"/> Lying Down <input type="checkbox"/> Medication <input type="checkbox"/> Nothing <input type="checkbox"/> Range of Motion <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Stretching <input type="checkbox"/> Chiropractic TX <input type="checkbox"/> Heat <input type="checkbox"/> Ice <input type="checkbox"/> Resting <input type="checkbox"/> Putting Knees to Chest <input type="checkbox"/> Laying on left Side <input type="checkbox"/> Laying on Right Side <input type="checkbox"/> Bending Left <input type="checkbox"/> Bending Right <input type="checkbox"/> Other(specify)
What makes it worse?	<input type="checkbox"/> Bending <input type="checkbox"/> Coughing <input type="checkbox"/> Sneezing <input type="checkbox"/> Lying Down <input type="checkbox"/> Lifting <input type="checkbox"/> Sitting <input type="checkbox"/> Prolonged Standing <input type="checkbox"/> Prolonged Walking <input type="checkbox"/> Normal Daily Activities <input type="checkbox"/> Bend to Left <input type="checkbox"/> Bend to the Right <input type="checkbox"/> Rotation Left <input type="checkbox"/> Rotation Right <input type="checkbox"/> Laying to Sitting <input type="checkbox"/> Laying to Standing <input type="checkbox"/> Sitting to Laying <input type="checkbox"/> Sitting to Standing <input type="checkbox"/> Standing to Layin <input type="checkbox"/> Standing to Sit <input type="checkbox"/> Bowel Movements <input type="checkbox"/> Other(specify)
Quality of the Pain?	<input type="checkbox"/> Ache <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing <input type="checkbox"/> Electric <input type="checkbox"/> Fiery <input type="checkbox"/> Shooting <input type="checkbox"/> Deep <input type="checkbox"/> Superficial <input type="checkbox"/> Other(specify)
Radiating (traveling pain)	<input type="checkbox"/> Left Buttock <input type="checkbox"/> Left Calf <input type="checkbox"/> Left Foot <input type="checkbox"/> Left Hip <input type="checkbox"/> Left Toes <input type="checkbox"/> Left Upper Back <input type="checkbox"/> Right Buttock <input type="checkbox"/> Right Calf <input type="checkbox"/> Right Foot <input type="checkbox"/> Right Hip <input type="checkbox"/> RightToes <input type="checkbox"/> Right Upper Back

	<input type="checkbox"/> Other (specify)
Timing	<input type="checkbox"/> Afternoon <input type="checkbox"/> During Night <input type="checkbox"/> Evening <input type="checkbox"/> During Light Activities <input type="checkbox"/> During Moderate Activities <input type="checkbox"/> Morning <input type="checkbox"/> Constant <input type="checkbox"/> Other (specify):
Side Effects	<input type="checkbox"/> Increased Sensitivity <input type="checkbox"/> Numbness <input type="checkbox"/> Stiffness <input type="checkbox"/> Tightness <input type="checkbox"/> Tingling <input type="checkbox"/> Other (specify):

PatientComments: _____

DoctorNotes: _____

OTHER	
Location	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center <input type="checkbox"/> Center and to the Left <input type="checkbox"/> Center and to the Right
Pain	<input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Burning
Severity	<input type="checkbox"/> Mild <input type="checkbox"/> Mild to Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate to Severe <input type="checkbox"/> Severe
Pain scale 0 No Pain 10 Excruciating Pain	No Pain 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Excruciating pain Please circle the number or if it is a half please put a line between the numbers
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Specific Site of Pain (Please Write in)	
Onset?	<input type="checkbox"/> At time of Accident <input type="checkbox"/> After Accident <input type="checkbox"/> Unknown <input type="checkbox"/> Specific Date (please write)
What makes it better? (Please Write in)	
What makes it worse? (Please Write in)	
Quality of the Pain?	<input type="checkbox"/> Ache <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing <input type="checkbox"/> Electric <input type="checkbox"/> Fiery <input type="checkbox"/> Shooting <input type="checkbox"/> Deep <input type="checkbox"/> Superficial <input type="checkbox"/> Other(specify)
Radiating (traveling pain) (Please Write in)	
Timing	<input type="checkbox"/> Afternoon <input type="checkbox"/> During Night <input type="checkbox"/> Evening <input type="checkbox"/> During Light Activities <input type="checkbox"/> During Moderate Activities <input type="checkbox"/> Morning <input type="checkbox"/> Constant <input type="checkbox"/> Other (specify):
Side Effects (Please Write In)	

PatientComments: _____

DoctorNotes: _____

OTHER COMPLAINTS (PLEASE CHECK ANY THAT APPLY):

- Balance loss Fatigue Irritability Memory loss Nervousness Tension Shortness of breath Loss of Sleep Vertigo/Dizzy Constipation Diarrhea Upset Stomach Ringing in the ear Difficulty dressing yourself

OtherComplaints: _____

Patient's Signature