

Patient Basic Information

PATIENT INFORMATION FORM

Name: _____ Nick Name: _____ [] Female
[] Male

Street Address: _____

City/State/Zip: _____ E-Mail: _____

Home Phone: _____ cell Phone: _____ work phone _____

Date of Birth: ___/___/___ Age: _____ Social Security #: _____

Employer: _____ Occupation: _____

Marital Status: (check) [] Single [] Married [] Widowed [] Separated [] Divorced

Spouse Name: _____ Spouse Social Security #: _____

Spouse Date of Birth _____ Spouse Employer: _____ Number of children: _____

Name of Nearest Relative Not Living With You: _____ Phone: _____

(If Under 18) Name of Parent or Guardian: _____

Parent of Guardian Home Phone: _____ Work Phone: _____

1. **Description /Onset * (What's going on)**

Enter a full description onset in the space below.

11. Emergency Room?

Home Work Hospital ER Private Doctor

How did you get there?

Self Somebody else Ambulance. Police

X-rays done? Ye+No Lab work? Ye+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 other doctor(s) seen prior to your first visit to this office.

1. Dr. _____ First visit date: ___/___/___

Specialty: _____ X-rays done? **Ye+No**

Types of treatments received: _____

How many treatments received? _____ Currently treating? **Ye+No**

Did treatments benefit you? **Ye+No**

Last visit date: ___/___/___

2. Dr. _____ First visit date: ___/___/___

Types of treatments received: _____

How many treatments received? _____ Currently treating: **Ye+No**

Did treatments benefit you? **Ye+No**

Last visit date: ___/___/___

Describe only ONE symptom per section.

1. Check only one body location below

- Headaches L R B
 Front of Head
 Top of Head
 Back of Head

- Jaw L R B
 Eye L R B
 Neck L R B
 Upper Back L R B
 Mid Back L R B
 Low Back L R B
 Chest L R B
 Abdomen L R B
 Ribs L R B
 Buttocks L R B
 Shoulder L R B
 Upper Arm L R B
 Forearm L R B
 Hand L R B
 Hip L R B
 Leg L R B
 Foot L R B

Other locations: _____

2. Types of pain

- Dull Sharp Aching Cutting
 Throbbing Burning Numbing Tingling
 Spasm Stinging Shooting Pounding

3. Pain Frequency

- Up to 1/4 of awake time 1/4 to 1/2 of time
 1/2 to 3/4 of awake time Most all the time

4. Pain Intensity (How it affects daily activities)

- Doesn't affect Somewhat affects
 Seriously affects Prevents activities

5. Does this pain radiate into other body parts?

- | | 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"/> |

Other locations of radiation: _____

Other types of pain:

6. Actions affecting this pain

- | | Brings On | Aggravates | Relieves |
|------------------------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> In the A.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> In the P.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending forward | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending back | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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| <input type="checkbox"/> Coughing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Straining | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Standing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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| <input type="checkbox"/> Sitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other Actions:

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 all, because of the pain".
Only fill in areas 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____ Stopping____ 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 had not been bothering me.
 My current complaints ALREADY existed and were worsened.

My most recent prior similar symptoms (if applicable) occurred____

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.

months ago / years ago **OR on** Date: ____/____/____

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