

PATIENT INJURY FORM

Name _____ Date of Birth _____ Today's Date: _____

Height: _____ ft _____ in Weight: _____ lbs. Pulse rate _____ Regular Irregular

My injury is: Work Related from _____/_____/_____ Due to an Auto Accident from _____/_____/_____

Presenting Problem(s):

A. Area(s) involved: (please circle)

shoulder arm elbow forearm wrist hand back
hip thigh leg knee ankle foot neck

B. Which side is involved? (please circle) Left Right Both

Please check all that apply to this current injury.

Mechanism of pain onset:

- | | |
|------------------------------------|---|
| <input type="checkbox"/> suddenly | <input type="checkbox"/> pulling |
| <input type="checkbox"/> gradually | <input type="checkbox"/> injured at work |
| <input type="checkbox"/> lifting | <input type="checkbox"/> hit in back |
| <input type="checkbox"/> twisting | <input type="checkbox"/> sports |
| <input type="checkbox"/> fall | <input type="checkbox"/> no apparent cause |
| <input type="checkbox"/> bending | <input type="checkbox"/> motor vehicle accident (car) |

What activities make the pain worse?

- | | |
|--|---|
| <input type="checkbox"/> during exercise | <input type="checkbox"/> bending forward |
| <input type="checkbox"/> after exercise | <input type="checkbox"/> bending backward |
| <input type="checkbox"/> sitting | <input type="checkbox"/> coughing |
| <input type="checkbox"/> standing | <input type="checkbox"/> sneezing |
| <input type="checkbox"/> walking | <input type="checkbox"/> bowel movements |

What reduces your pain?

- | | |
|---|---|
| <input type="checkbox"/> lying down | <input type="checkbox"/> pain pills |
| <input type="checkbox"/> sitting | <input type="checkbox"/> muscle relaxants |
| <input type="checkbox"/> standing | <input type="checkbox"/> aspirin |
| <input type="checkbox"/> walking | <input type="checkbox"/> nothing |
| <input type="checkbox"/> manipulation | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> physical therapy | |

Have you had any *diagnostic studies other than routine x-rays*? Yes No

If yes, please check the appropriate tests below with date of tests if you know them

- | | | | |
|------------------------------------|------------|------------------------------------|------------|
| <input type="checkbox"/> CAT scan | date _____ | <input type="checkbox"/> discogram | date _____ |
| <input type="checkbox"/> myelogram | date _____ | <input type="checkbox"/> MRI | date _____ |
| <input type="checkbox"/> EMG | date _____ | <input type="checkbox"/> Bone Scan | date _____ |

Do you have any *back pain*? Yes No If yes, how long? _____ years _____ months _____ weeks

Do you have any *neck pain*? Yes No If yes, how long? _____ years _____ months _____ weeks

Do you have any *leg or joint pain*? Yes No If yes, how long? _____ years _____ months _____ weeks

Do you have any *arm or joint pain*? Yes No If yes, how long? _____ years _____ months _____ weeks

What other *types of doctors* have you seen for your back or neck problem (for example; chiropractors)?

Do you have any *additional information*, which would be helpful to understand your problem?

PLEASE TURN PAGE OVER. THANK YOU.

Physician Signature _____ Date _____

PAIN ASSESSMENT

How bad is your back/neck pain now?

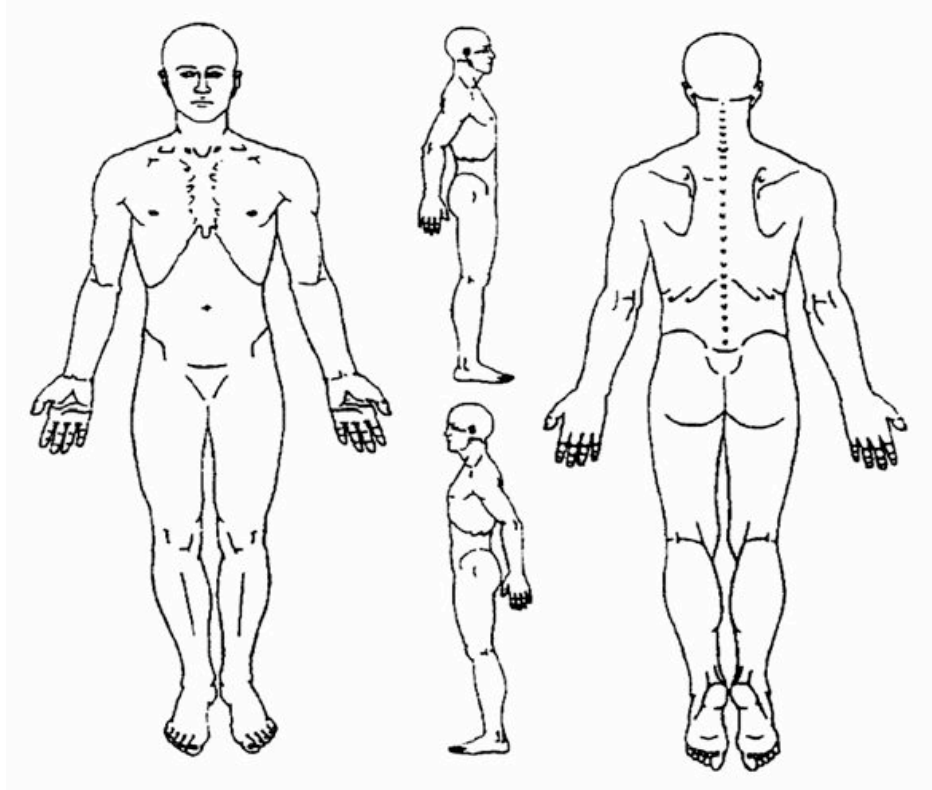
0 _____ 10
no pain _____ worst possible

How bad is your leg/arm pain now?

0 _____ 10
no pain _____ worst possible

Mark the areas on your body where you feel the described pain.

- | | | |
|-------------------|-----------------------------|----------------------|
| 1. numbness ----- | 3. stabbing /////
000000 | 5. deep boring ##### |
| 2. burning xxxxxx | 4. pins & needles | 6. dull, achy yyyyyy |



CHECKLIST

Treatment(s) that you *tried* for your orthopaedic problem: (for example; treatment to this point in time)

- | | |
|---|--|
| <input type="checkbox"/> Jogging or Aerobic Exercises | <input type="checkbox"/> Stop Smoking |
| <input type="checkbox"/> Physical Therapy (how long? ____ wk ____ months) | <input type="checkbox"/> Chiropractic Care (how long? ____ wk ____ months) |
| <input type="checkbox"/> Nonsteroidal Anti-inflammatory Medication (e.g. Ibuprofen, Advil, etc) | <input type="checkbox"/> Oral Steroid Like Prednisone |
| <input type="checkbox"/> Epidural Steroids | <input type="checkbox"/> Local Office Back or Buttock Cortisone Injection |
| <input type="checkbox"/> racing | <input type="checkbox"/> TENS Unit |
| <input type="checkbox"/> Chronic Pain Management Program | <input type="checkbox"/> Narcotics Like Codeine, Percocet, Vicodin |
| <input type="checkbox"/> Muscle Relaxers | <input type="checkbox"/> Surgery (date(s) _____) |
| <input type="checkbox"/> Traction | <input type="checkbox"/> Massage |
| <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Yoga/Meditation/Acupuncture |
| <input type="checkbox"/> Vitamin Therapy | <input type="checkbox"/> Glucosamine (Chondrotin) |
| <input type="checkbox"/> Calcium | <input type="checkbox"/> Estrogen |
| <input type="checkbox"/> Other (list) _____ | |

I have reviewed all pages as part of the patient's visit.

Patient Signature

Date