



CONFIDENTIAL PATIENT INFORMATION

Date: _____

Patient Name: _____ Date of Birth: _____ Gender: M F

Home Phone #: (____) _____ Mobile #: (____) _____ SS#: _____

Address: _____

City/Town: _____ State: _____ Zip Code: _____

Employer's Name: _____ Employer Phone: (____) _____

Emergency Contact: _____ Emergency Phone: (____) _____

Auto Insurance Company: _____

Address: _____

City/Town: _____ State: _____ Zip Code: _____

Adjuster: _____ Adjuster Phone : (____) _____ ext. _____

Claim Number: _____ Insured's Name: _____

Health Insurance Company: _____

Address: _____

City/Town: _____ State: _____ Zip Code: _____

Phone Number: (____) _____ Patient ID #: _____

Insured's Name: _____

Representing Attorney: _____

Address: _____

City/Town: _____ State: _____ Zip Code: _____

Phone Number: (____) _____ Fax #: _____

QUESTIONNAIRE (GENERAL INFORMATION)

Patient Name: _____ **Date Injury Occurred:** _____

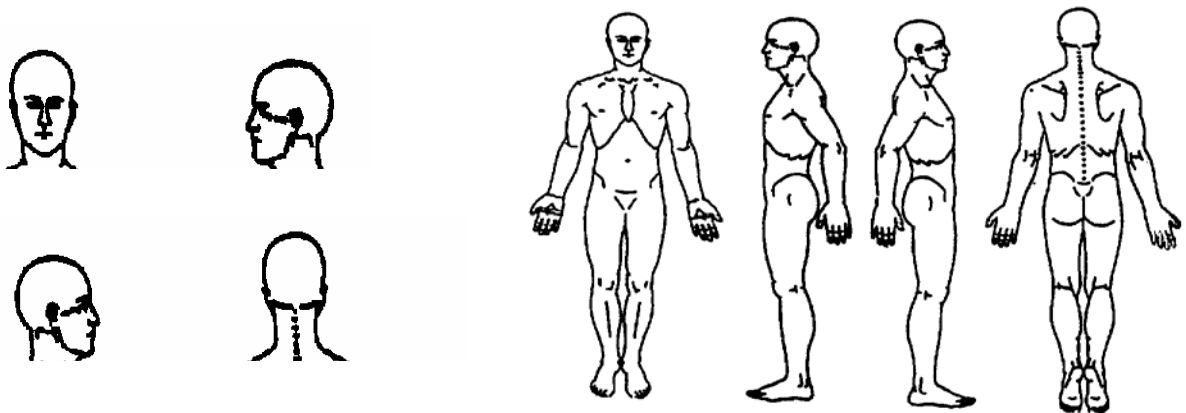
What medications are you currently taking at this time? _____

Do you or your family have any medical problems? _____
(Diabetes - High Blood Pressure - Cancer - Etc...)

Do you Smoke? Yes No How often? _____
(circle)

Do you Drink? Yes No How often? _____
(circle)

Please mark your areas of pain or discomfort on the figures below:



When your accident occurred, did you feel any tearing or ripping? Yes No

Are your symptoms affecting your work or daily activities? Yes No

What time of the day is the pain / discomfort the worse? Morning Afternoon Night
(circle)

Do you have difficulty sleeping? Yes No

What posture(s) aggravates the pain / discomfort? _____

What affects the pain / discomfort more? Heat Cold

Does the pain / discomfort wake you up at night? Yes No

Does the pain go up and down your spine? Yes No

Does aspirin relieve your pain? Yes No

Does coughing or sneezing increase you pain? Yes No

QUESTIONNAIRE (LOWER BACK / NECK / DISABILITY)

Patient Name: _____ Date Injury Occurred: _____

LOWER BACK SYMPTOMS

Are you experiencing lower back pain?	Yes	No
Do you have numbness or tingling in your feet?	Yes	No
Does the pain go down your legs?	Yes	No
Does the pain radiate into your stomach?	Yes	No
Is there impairment of bowel function?	Yes	No
Are you experiencing knee pain?	Yes	No
Are you experiencing ankle pain?	Yes	No

NECK SYMPTOMS

Are you experiencing neck pain?	Yes	No
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What type of pain(s) are you experiencing?

(Exp: Stabbing, Throbbing, Sharp, Dull, Cramping, Grabbing)

Is there pain in your:

Left Arm

Left Shoulder

Right Arm

Right Shoulder

Do you feel numbness in your arms?	Yes	No
Do you feel numbness in your hands?	Yes	No
Do you have difficulty swallowing?	Yes	No
Do you have chest pain?	Yes	No
Has your nervousness increased?	Yes	No
Does the neck pain affect your vision, hearing, or balance?	Yes	No

DISABILITY

How many day or weeks of work have you lost? _____

What physical restrictions do you have? _____