RECOVERY CHIROMED

Personal Injury Questionnaire/Medical History

Full Name: _____ Birthdate: _____ Sex: ___ M ___ F
Address: _____
City: _____ State: _____ Zip: _____
Height: _____ Weight: _____ Social Security #: _____
Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed
Home Phone: _____ Employer: _____
Cell Phone: _____ Occupation: _____
Work Phone: _____ Email Address: _____
Emergency Contact Name:_____ Contact Phone #: _____
Date of Accident: _____ How were you referred to this office? _____

Chief Complaints: (please circle all that you have experienced since the accident**)**

Headaches Neck Pain Lower Back Pain Middle Back Pain Hip Pain: L R
Dizziness Weakness Shoulder Pain: L R Arm/Hand Pain: L R Leg/Pain: L R
Other: _____

Is the pain/discomfort constant? ____ Yes ____ No **Is pain on and off (intermittent)** ___ Yes ___ No

How would you describe the pain/discomfort? (please circle all that apply)

Sharp/Stabbing Dull Achy Cramping Soreness
Other: _____

How would you rate the pain? 10 being the worst possible pain and 0 being no pain. (please circle)

0 1 2 3 4 5 6 7 8 9 10

What makes your pain/discomfort worse? (please circle all that apply)

Sitting Standing Sneezing Coughing Moving arms or legs Lifting
Twisting Bathing Dressing Moving head Bending forward Rising from a chair
Driving Moving head Other: _____

Do you have any of the following? (please circle all that apply)

Right arm/hand: numbness pain tingling **Right leg/foot**: numbness pain tingling
Left arm/hand: numbness pain tingling **Left leg/foot**: numbness pain tingling

What have you been doing to decrease your pain/discomfort? (please circle all that apply)

Heating Pad Moving around Resting Sitting Ice
Standing Leaning forward Leaning to Side Laying on back Hot bath/shower
Other: _____

When did the pain/discomfort begin after the accident? (please circle)

Immediately Within 12 Hours Next Day 2 days later 3 days later Other: _____

Have you ever experienced this pain/discomfort before? __ Yes __ No If so, how long ago? _____

CAR ACCIDENT Details:

Where were you seated in the vehicle at the time of impact? (please circle)

Driver Front Passenger Rear Left Passenger Rear Right Passenger

Where were you looking at the time of impact? (please circle)

Straight Ahead To the Right To the Left To the Rear At Rear-View Mirror

Were both of your hands on steering wheel, dash, or front seat at time of impact? ____ Yes ____ No

If you were driving, was your foot on the brake pedal at time of impact? ____ Yes ____ No

Did you anticipate the crash or see that it was going to happen? ____ Yes ____ No

Were you wearing your seatbelt? ____ Yes ____ No **Did airbags deploy?** ____ Yes ____ No

Did you hit your head on anything? ____ Yes ____ No **Did you lose consciousness?** ____ Yes ____ No

Describe in detail how the recent accident occurred: _____

_____

_____

_____

_____

Did you receive medical treatment after the accident? ____ Yes ____ No

If yes, where did you go: _____

Were x-rays, MRI, or CT scans performed? ____ Yes ____ No

What, if any, treatment was recommended? (please circle)

Prescription Drugs Injection Advised me to see another doctor

Did you see another doctor for these conditions? ____ Yes ____ No

If yes, what was the Doctor's name? _____

What is this Doctor's specialty? (please circle)

Orthopedist Chiropractor Neurologist Family/General

Other: _____

Were further diagnostic test performed? (please circle)

MRI CT Scan Myelogram Other: _____

If so, where were they performed? _____

What type of treatment was rendered?

Prescriptions/Injections – please list _____

Chiropractic – Approximately how many treatments? _____

Physical Therapy – Approximately how many treatments? _____

Surgery (please list) _____

What percent better do you feel since beginning these treatments? (please circle)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

What medications/vitamins/supplements do you currently take? (please circle and write dosage)

Blood Pressure: _____ Cholesterol: _____ Diabetic: _____
Multi-Vitamins: _____ Supplements: _____
Over the counter meds: _____
Other Medication: _____

Have you ever had a broken/fractured bone? _____ Yes _____ No
If so, please specify what was fractured and how long ago_____

Please list all past surgeries/hospitalizations and include approximate date(s):

_____

_____

Do you suffer from or have you been diagnosed with any of the following conditions? (please check)

___ AIDS	___ Alcoholism	___ Anorexia	___ Arthritis
___ Asthma	___ Bed Wetting	___ Bladder Trouble	___ Bleeding Disorders
___ Breast Disease	___ Cancer	___ Cataracts	___ Diabetes
___ Discolored Urine	___ Dizziness	___ Emphysema	___ Epilepsy
___ Glaucoma	___ Gout	___ Heart Problems	___ Hepatitis
___ Herniated Disc	___ High Blood Pressure	___ High Cholesterol	___ Irritability
___ Kidney Problems	___ Liver Problems	___ Menstrual Cramping	___ Menstrual Irregularity
___ Mononucleosis	___Multiple Sclerosis	___ Nervousness	___ Pacemaker
___ Prostate Problems	___ Psychiatric Care	___ Rheumatoid Arthritis	___ Sexual Dysfunction
___ Stroke	___ Stress	___ Thyroid Problems	___ Tumors

Other: _____

Do you exercise? ____ Yes ____ No **Approximately how much per week?** _____
Do you smoke cigarettes/cigars? ____ Yes ____ No **Approximately how many per day?** _____
Do you drink alcohol? ____ Yes ____ No **Approximately how many per week?** _____

FEMALES ONLY: When was your last menstrual cycle? _____ Are you pregnant? ____ Yes ____ No

Do the following relatives suffer from any of the following? (please check the condition)

	Mother	Father	Sibling 1	Sibling 2	Sibling 3	Sibling 4
Diabetes						
Heart Disease						
High Blood Press						
Stroke						
Cancer						
Living						
Deceased						

I certify that this information is true to the best of my knowledge.

_____ _____
Patient/Guardian Signature Date