NAME: _____ DATE: _____

What is being examined today? _____ Which side? (RIGHT/LEFT) _____

Were X-RAYS/MRI taken? ☐ YES ☐ NO Did you bring them in? ☐ YES ☐ NO

1. DATE of accident, **OR** HOW LONG have you had ILLNESS/PROBLEM/SYMPTONS: _____

2. BRIEFLY DESCRIBE illness/injury/symptoms requiring treatment below (@***HOW**) and include:

   a. **WHERE** it occurred: ☐ HOME ☐ SCHOOL ☐ OTHER (PLEASE SPECIFY): _____

   ☐ WORK (If so, did it occur while working for wages? ☐ YES ☐ NO ☐ UNSURE)

   ☐ MOTOR VEHICLE ACCIDENT (If so, do you have auto insurance? ☐ YES ☐ NO)

   *b. **HOW** illness/problem/symptoms/accident occurred: _____

   _____

   _____

   _____

   _____

   c. Is there a third party involved? ☐ YES ☐ NO

3. Have you seen a physician for this problem? ☐ YES ☐ NO

   a. DOCTOR: _____ ADDRESS: _____

   b. TREATMENT (special tests, injections, medications, etc.):

   _____

   _____

4. Have you had a previous problem in this area? ☐ YES ☐ NO If so, please describe:

   _____

   _____

   _____

   _____

5. Have you lost time from work because of this current injury/problem? ☐ YES ☐ NO

   If yes, DATE LAST WORKED: _____

6. Briefly describe your job activities: (lifting, pushing, pulling, driving, etc.)

   _____

   _____

7. Please describe present complaints:

   _____

   _____

   _____

   _____

   _____

8. Do you feel your symptoms are: ☐ IMPROVED ☐ MORE SEVERE ☐ REMAINED THE SAME

NAME : _____ DATE : _____

GENERAL HEALTH (CIRCLE ONE) GOOD FAIR POOR

YES _____ NO _____ HAVE YOU EVER BEEN SERIOUSLY ILL ?

YES _____ NO _____ HAVE YOU EVER BEEN HOSPITALIZED ?

YES _____ NO _____ HAVE YOU HAD SURGERY ? WHEN _____

WHAT KIND ? _____

YES _____ NO _____ ARE YOU PREGNANT?

HAVE YOU EVER HAD :

YES _____ NO _____ CANCER

YES _____ NO _____ HEART TROUBLE

YES _____ NO _____ DIFFICULTY WITH BREATHING

YES _____ NO _____ LUNG DISEASE (FOR INSTANCE : PNEUMONIA, ASTHMA OR EMPHYSEMA)

YES _____ NO _____ JAUNDICE, HEPATITIS

YES _____ NO _____ DIABETES

YES _____ NO _____ FAINTING SPELLS

YES _____ NO _____ ALLERGIES TO MEDICATIONS (IF YES, WHAT MEDICATIONS AND WHAT TYPE OF REACTION; RASH, SWELLING, etc.) _____

_____

YES _____ NO _____ RHEUMATIC FEVER

YES _____ NO _____ HIGH BLOOD PRESSURE

YES _____ NO _____ ANEMIA OR BLEEDING PROBLEMS

YES _____ NO _____ OTHER SERIOUS PROBLEMS : WHAT _____

YES _____ NO _____ STOMACH ULCERS

YES _____ NO _____ TAKE MEDICATION REGULARLY (INCLUDING BIRTH CONTROL PILLS)

WHAT KIND _____

_____

_____

YES _____ NO _____ SMOKE _____ PKG / DAY

YES _____ NO _____ DRINK ALCOHOL (IF SO, DO YOU HAVE IT DAILY, SOCIALLY, OCCASIONALLY, RARELY) _____

HAVE YOU EVER HAD :

YES _____ NO _____ BROKEN BONES (IF SO, WHICH ONES AND WHEN) _____

_____

YES _____ NO _____ HEAD INJURIES : WHEN _____

YES _____ NO _____ NECK INJURIES : WHEN _____

YES _____ NO _____ BACK INJURIES : WHEN _____

HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY EVER HAD :

YES _____ NO _____ CANCER YES _____ NO _____ LUNG DISEASES, TB, etc.

YES _____ NO _____ HEART DISEASE YES _____ NO _____ DIABETES

HT : _____ WT: _____ RIGHT / LEFT HANDED _____

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