

# NEW PATIENT INFORMATION

For Office use only  
Patient # \_\_\_\_\_

Date \_\_\_\_\_

Patient's First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer Name \_\_\_\_\_

Job Title \_\_\_\_\_ Work Phone # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender  Male  Female Handedness? R L

Weight \_\_\_\_\_ Height \_\_\_\_\_ Marital Status S M W D

Spouse's Name \_\_\_\_\_ Spouse's Date of Birth \_\_\_\_\_

In case of an emergency who should we contact? \_\_\_\_\_

Phone # \_\_\_\_\_

## PRESENT HEALTH

Please list any medications you are currently taking? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you received any medical treatment since your accident? Y N

Hospital \_\_\_\_\_

When? (Days/Weeks/Months/Years) \_\_\_\_\_

Medical Doctor \_\_\_\_\_

When? (Days/Weeks/Months/Years) \_\_\_\_\_

Chiropractor \_\_\_\_\_

When? (Days/Weeks/Months/Years) \_\_\_\_\_

Physical Therapy \_\_\_\_\_

When? (Days/Weeks/Months/Years) \_\_\_\_\_

Other \_\_\_\_\_

When? (Days/Weeks/Months/Years) \_\_\_\_\_

### MEDICAL HISTORY

As a child, did you have any of the following diseases?

Scarlet fever     Rheumatic fever     Diphtheria     Mumps     Measles

German measles     Other: \_\_\_\_\_

List any hospitalizations or surgeries you had with corresponding dates? \_\_\_\_\_

Have you ever been in a prior auto accident? \_\_\_\_\_ When? \_\_\_\_\_

Were you treated for injuries and what type of injuries? \_\_\_\_\_

List other injuries including falls and other traumas and when they occurred: \_\_\_\_\_

Have you been diagnosed with any diseases or disorders and when? \_\_\_\_\_

SYMPTOMS

Patient's Name \_\_\_\_\_ Date of incident \_\_\_\_\_ Today's Date \_\_\_\_\_

CIRCLE ALL YOUR COMPLAINTS

1. DO YOU HAVE LACERATIONS, CUTS OR BRUISING? :

- a. Head or Face
- b. Neck
- c. Seat belt bruising
- d. Cuts or bruising on your chest
- e. Cuts or bruising on arms
- f. Cuts or bruising on legs
- g. Other: \_\_\_\_\_

2. HEAD INJURIES: (now or at the time of the accident)

- a. Were you knocked out or unconscious
- b. Headaches
- c. Face pain
- d. Pupils different sizes
- e. Dizziness
- f. Difficulty walking
- g. Balance problems
- h. Room spins
- i. Disoriented Confusion
- j. Day dreaming
- k. Attention problems
- l. Hearing problems
- m. Change in sense of smell or taste
- n. Difficulty speaking
- o. Memory problems
- p. Very tired or fatigued
- q. Appetite change
- r. Sleep difficulties
- s. Visual Disturbances, blurry or double vision
- t. Flashbacks to accident
- u. Problems to read or write
- v. Problems adding or subtracting
- w. Problems learning new things
- x. Problems understanding
- y. Problems remembering numbers
- z. Difficulty Concentrating
- aa. Difficulty remembering things
- bb. Difficulty making decisions
- cc. Change in Sexual Functioning
- dd. Nausea / Vomiting

- ee. Change of personality
  - ff. Wanting to be alone
  - gg. Mood swings
  - hh. Sadness
  - ii. Agitation
  - jj. Anger
  - kk. Helplessness
  - ll. Reduce confidence
  - mm. Apathy
  - nn. Irritability
  - oo. Sleepiness
  - pp. Frustration
  - qq. Impatience
  - rr. Other head related issues
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3. JAW PROBLEMS:

- a. Jaw pain
- b. Clicking
- c. Pain while chewing
- d. Pain while talking
- e. Pain while yawning
- f. Pain while moving jaw from side to side

4. NECK INJURIES:

- a. Neck pain
- b. Neck pain, numbness, tingling, weakness that radiates or goes down to RIGHT shoulder, arm, forearm or hand
- c. Neck pain, numbness, tingling, weakness that radiates or goes down to LEFT shoulder, arm, forearm or hand
- d. Neck pain, numbness, tingling, weakness that radiates or goes down to RIGHT UPPER BACK
- e. Neck pain, numbness, tingling, weakness that radiates or goes down to LEFT UPPER BACK
- f. Neck pain that causes headaches

Patient's Signature: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Injury: \_\_\_\_\_ Today's Date: \_\_\_\_\_

- g. Neck spasms or shoulder spasms
  - h. Popping, clicking or clunking sound with neck movement
- a. Dull
  - b. Ache
  - c. Sharp
  - d. Stabbing
  - e. Other

5. SHOULDER INJURIES

- a. Shoulder pain LEFT RIGHT BOTH
- b. Shoulder pain with movement L R BOTH
- c. Shoulder spasms LEFT RIGHT BOTH
- d. Sharp shoulder pain
- e. Dull shoulder pain
- f. Achy shoulder pain
- g. Pins and needles shoulder pain
- h. Shoulder pain that radiates or shoots pain into arm
- i. Other:

6. UPPER ARM PAIN: RIGHT LEFT BOTH

- a. Dull
- b. Ache
- c. Sharp
- d. Stabbing
- e. Other

7. ELBOW PAIN: RIGHT LEFT BOTH

- a. Dull
- b. Ache
- c. Sharp
- d. Stabbing
- e. Other

8. FOREARM: RIGHT LEFT BOTH

- a. Dull
- b. Ache
- c. Sharp
- d. Stabbing
- e. Other

9. WRIST PAIN: RIGHT LEFT BOTH

10. HAND PAIN: RIGHT LEFT BOTH

- a. Dull
- b. Ache
- c. Sharp
- d. Stabbing
- e. Other

11. MID BACK PAIN OR UPPER BACK PAIN

- a. Upper or mid back pain
- b. Upper back pain, numbness, tingling, weakness that radiates or goes down to RIGHT shoulder, arm, forearm or hand
- c. Upper back pain, numbness, tingling, weakness that radiates or goes down to LEFT shoulder, arm, forearm or hand

d. Upper or mid back spasms

12. LOW BACK PAIN:

- a. Low back pain
- b. Low back pain, numbness, tingling, weakness that radiates or goes down to RIGHT buttock, thigh, leg or foot
- c. Low back pain, numbness, tingling, weakness that radiates or goes down to LEFT buttock, thigh, leg or foot

d. Low back spasms

13. PELVIC OR SACRAL PAIN

- a. Pelvic pain, numbness, tingling, weakness that radiates or goes down to RIGHT buttock, thigh, leg or foot
- b. Pelvic pain, numbness, tingling, weakness that radiates or goes down to LEFT buttock, thigh, leg or foot

Patient's Signature: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Injury: \_\_\_\_\_ Today's Date: \_\_\_\_\_

c. Sacral pain (tail bone)

d. Coccygeal or coccyx (tail bone) pain

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14. HIP PAIN: RIGHT LEFT BOTH

a. Left hip pain

b. Left hip pain, numbness, tingling, weakness that radiates or goes down to LEFT buttock, thigh, leg or foot

c. Right hip pain

d. Right hip pain, numbness, tingling, weakness that radiates or goes down to RIGHT buttock, thigh, leg or foot

15. UPPER LEG PAIN: RIGHT LEFT BOTH

a. Upper leg pain that radiates to knee

b. Upper leg spasms

16. KNEE PAIN: RIGHT LEFT BOTH

a. Knee pain that radiates to calf

b. Knee pain that radiates to calf and ankle

c. Knee pain that radiates to calf, ankle and foot

17. ANKLE PAIN: RIGHT LEFT BOTH

a. Ankle pain that radiates to foot

b. Ankle and foot pain

18. FOOT PAIN: RIGHT LEFT BOTH

19. CHEST PAIN

20. STOMACH PAIN

21. OTHER SYMPTOMS:

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Patient's Signature: \_\_\_\_\_

# Review of Symptoms

Patient Name: \_\_\_\_\_

Patient File #: \_\_\_\_\_

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**INSTRUCTIONS:** Please fill out all of the sections. If none of the conditions apply, select "None."

**Constitutional:**

- None
- Chills
- Daytime Drowsiness
- Fatigue
- Fever
- Night Sweats
- Weight Gain
- Weight Loss

**Eyes/Vision:**

- None
- Blindness
- Blurred Vision
- Cataracts
- Change in Vision
- Double Vision
- Eye Pain
- Field Cuts
- Glaucoma
- Itching (around the eyes)
- Photophobia
- Tearing
- Wears Glasses or Contacts

**Ears, Nose and Throat:**

- None
- Bleeding
- Dental Implants
- Dentures
- Difficulty Swallowing
- Discharge
- Dizziness
- Ear Drainage
- Ear Infection(s)
- Ear Pain
- Fainting
- Headaches
- Head Injury (history of)
- Hearing Loss
- Hoarseness
- Loss of Smell
- Nasal Congestion
- Nose Bleeds
- Post Nasal Drip
- Rhinorrhea (runny nose)
- Sinus Infections
- Snoring
- Sore Throats
- Tinnitus (ringing in the ears)
- TMJ Disorder

**Cardiovascular:**

- None
- Angina (chest pain or discomfort)
- Chest Pain
- Claudication (leg pain or achiness)
- Heart Murmur
- Heart Problems
- Orthopnea (difficulty breathing while lying)
- Palpitations (irregular or forceful heart beat)
- Paroxysmal Nocturnal Dyspnea (shortness of breath at night)
- Shortness of Breath
- Swelling of Leg(s)
- Ulcers
- Varicose Veins

**Gastrointestinal:**

- None
- Abdominal Pain
- Belching
- Black, Tarry Stools
- Constipation
- Diarrhea
- Difficulty Swallowing
- Heartburn
- Hemorrhoids
- Indigestion
- Jaundice (yellowing of the skin)
- Nausea
- Rectal Bleeding
- Abnormal Stool Caliber (quality)
- Abnormal Stool Color
- Abnormal Stool Consistency
- Vomiting
- Vomiting Blood

**Respiration:**

- None
- Asthma
- Coughing up blood
- Shortness of Breath
- Sputum Production
- Wheezing

**Endocrine:**

- None
- Cold Intolerance
- Diabetes
- Excessive Appetite
- Excessive Hunger
- Excessive Thirst
- Frequent Urination
- Goiter
- Hair Loss
- Heat Intolerance
- Unusual Hair Growth
- Voice Changes

**Skin:**

- None
- Changes in Nail Texture
- Changes in Skin Color
- Hair Growth
- Hair Loss
- Hives
- Itching
- Paresthesia (numbness, prickling, or tingling)
- Rash
- History of Skin Disorders
- Skin Lesions or Ulcers
- Varicosities

**Nervous System:**

- None
- Dizziness
- Facial Weakness
- Headaches
- Limb Weakness
- Loss of Consciousness
- Loss of Memory
- Numbness
- Seizures
- Sleep Disturbance
- Slurred Speech
- Stress
- Strokes
- Tremors
- Unsteadiness of Gait

**Allergy:**

- None
- Anaphylaxis (history of)
- Food Intolerance
- Itching
- Nasal Congestion
- Sneezing

**Hematology:**

- None
- Anemia
- Bleeding
- Blood Clotting
- Blood Transfusion(s)
- Bruises easily
- Fatigue
- Lymph Node Swelling

**Psychological:**

- None
- Anhedonia (inability to experience joy or enjoy life)
- Anxiety
- Appetite Changes
- Behavioral Change(s)
- Bipolar Disorder
- Confusion
- Convulsions
- Depression
- Insomnia
- Memory Loss
- Mood Change(s)

**Female:**

- None
- Birth Control Therapy
- Breast Lumps / Pain
- Burning Urination
- Cramps
- Frequent Urination
- Hormone Therapy
- Irregular Menstruation
- Urine Retention
- Vaginal Bleeding
- Vaginal Discharge

**Male:**

- None
- Burning Urination
- Erectile Dysfunction
- Frequent Urination
- Hesitancy or Dribbling
- Prostate Problems
- Urine Retention

Patient Signature: \_\_\_\_\_

**FOR OFFICE USE ONLY:**

I have reviewed the above ROS with the above named patient:

\_\_\_\_\_  
Doctor Signature

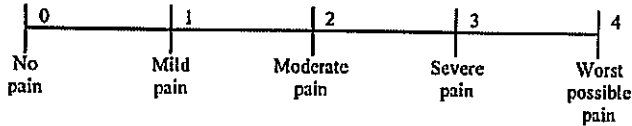
\_\_\_\_\_  
Date

# Functional Rating Index

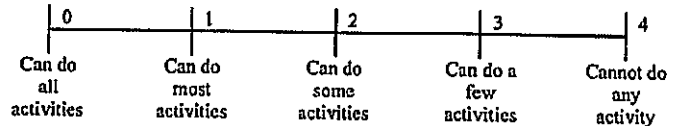
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems has affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

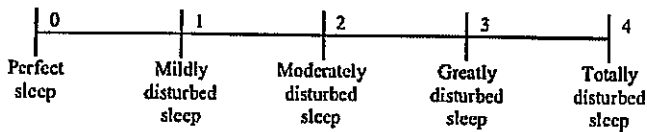
## 1. Pain Intensity



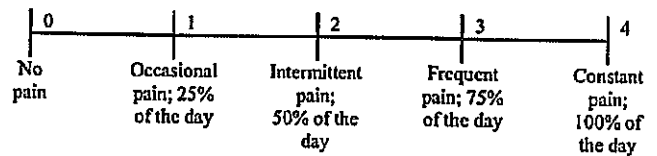
## 6. Recreation



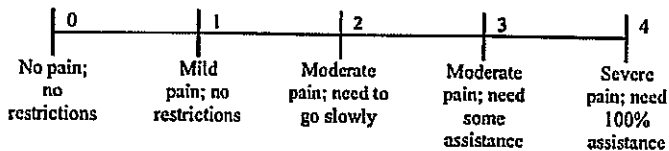
## 2. Sleeping



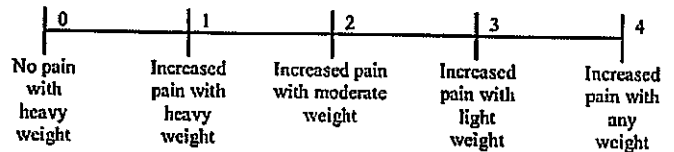
## 7. Frequency of Pain



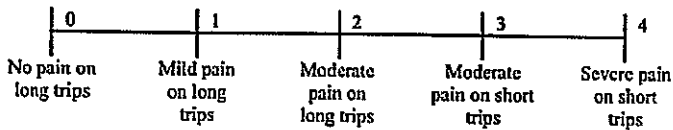
## 3. Personal Care (washing, dressing, etc.)



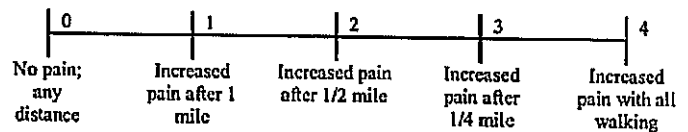
## 8. Lifting



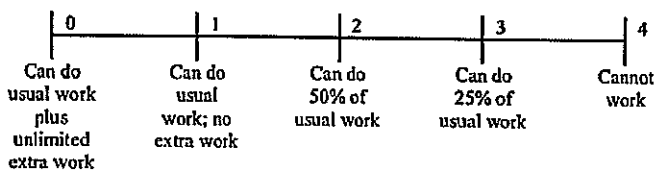
## 4. Travelling (driving, etc.)



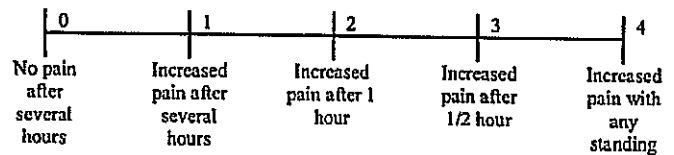
## 9. Walking



## 5. Work



## 10. Standing



\_\_\_\_\_  
 Patient's Signature

\_\_\_\_\_  
 Date

### For Office Use Only:

Practitioner ID#: \_\_\_\_\_  
 Total Score \_\_\_\_\_ / 40

Clinical Diagnosis Codes:

Patient ID#: \_\_\_\_\_