

**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 including **ALL** medications prescribed to you from this current injury? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you received any medical treatment for this (current) motor vehicle collision? Y N

Name of Hospital you received treatment? (write N/A if you didn't go to the hospital)  
\_\_\_\_\_

Date of Treatment at hospital? \_\_\_\_\_

Name of Doctor or Urgent Care Facility you received treatment? (**not including here**)  
\_\_\_\_\_Date of Treatment at Doctor or Urgent Care Facility? (**not including here**)  
\_\_\_\_\_Name of Physical Therapy Facility you received treatment? (**not including here**)  
\_\_\_\_\_  
\_\_\_\_\_

Date of Treatment at Physical Therapy Facility? **(not including here)**

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Name of Orthopedist or Pain Management Facility you received treatment?

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Date of Treatment at Orthopedist or Pain Management Facility?

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List **ANY** surgeries you have had associated with this current collision and the dates? \_\_\_\_\_

### PAST MEDICAL HISTORY

Have you ever been in a motor vehicle collision? **(not including the collision you are here today for)** Date? (please give year and approximate month) **Please include ALL history of Collisions**

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Were you injured? Y or N What part(s) of your body was injured?

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Where did you go for treatment for these injuries (Please include **ALL Treatment Facilities** or **names of Doctors**)

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List **ALL** other injuries including falls and other traumas and when they occurred:

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MEDICAL HISTORY QUESTIONNAIRE

TODAY'S DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ Male/Female AGE: \_\_\_\_\_ DOB: \_\_\_\_\_

**\*\*\*Since this is your medical history and it will be used in evaluating your health, it is extremely important that the questions be answered as accurately and completely as possible. All information is kept confidential. \*\*\***

Providers:

Primary Care Provider \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Any Other Provider assisting in your care: \_\_\_\_\_

**Past Medical History (Please check any medical problems that you have had in the past)**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Abnormal pap smear | <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Irregular menses                     |
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> COPD (lung disease)      | <input type="checkbox"/> Kidney disease                       |
| <input type="checkbox"/> Allergies          | <input type="checkbox"/> Coronary artery disease  | <input type="checkbox"/> Liver disease                        |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Depression               | <input type="checkbox"/> Menorrhagia                          |
| <input type="checkbox"/> Anxiety            | <input type="checkbox"/> Diabetes mellitus        | <input type="checkbox"/> Myocardial infarction (heart attack) |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Diverticulitis           | <input type="checkbox"/> Nerve/muscle disease                 |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> GERD (heartburn)         | <input type="checkbox"/> Osteoporosis                         |
| <input type="checkbox"/> Blood transfusion  | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Seizures                             |
| <input type="checkbox"/> Headaches          | <input type="checkbox"/> Sickle cell anemia       | <input type="checkbox"/> Cancer                               |
| <input type="checkbox"/> Heart murmur       | <input type="checkbox"/> Sleep apnea              | <input type="checkbox"/> Cataracts                            |
| <input type="checkbox"/> HIV/AIDS           | <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Clotting disorder                    |
| <input type="checkbox"/> Substance abuse    | <input type="checkbox"/> Colonic adenoma          | <input type="checkbox"/> Hypertension (high blood pressure)   |
| <input type="checkbox"/> Tuberculosis       | <input type="checkbox"/> Concussion               | <input type="checkbox"/> Hyperlipidemia (high cholesterol)    |
| <input type="checkbox"/> Hypothyroidism     | <input type="checkbox"/> Ulcers                   | <input type="checkbox"/> BPH (benign prostatic hyperplasia)   |

☐ Other (list) \_\_\_\_\_

**Past Surgical History (Check any surgeries you have had and the date of surgery if you know it)**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Appendectomy                           | <input type="checkbox"/> Cosmetic surgery               | <input type="checkbox"/> Prostate surgery                |
| <input type="checkbox"/> Bariatric surgery                      | <input type="checkbox"/> Eye surgery                    | <input type="checkbox"/> Small intestine surgery         |
| <input type="checkbox"/> Brain surgery                          | <input type="checkbox"/> Fracture surgery               | <input type="checkbox"/> Spine surgery                   |
| <input type="checkbox"/> Breast surgery                         | <input type="checkbox"/> Hernia repair                  | <input type="checkbox"/> Tonsillectomy and Adenoidectomy |
| <input type="checkbox"/> CABG (bypass)                          | <input type="checkbox"/> Hysterectomy (ovaries removed) | <input type="checkbox"/> Tubal ligation (tubes tied)     |
| <input type="checkbox"/> Cesarean section                       | <input type="checkbox"/> Hysterectomy (ovaries remain)  | <input type="checkbox"/> Valve replacement               |
| <input type="checkbox"/> Joint replacement                      | <input type="checkbox"/> Vasectomy                      | <input type="checkbox"/> Colon surgery                   |
| <input type="checkbox"/> Cholecystectomy (gall bladder removal) |   |  |
| <input type="checkbox"/> Other (list) _____                     |   |  |

Additional Information:

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**Past and Present Medical Problems:**

High blood pressure	Yes	No	Heart attack	Yes	No	High cholesterol	Yes	No
Stroke/TIA	Yes	No	Heart Failure	Yes	No	Atrial Fib/Arrhythmia	Yes	No
PFO/ Hole in Heart	Yes	No	Cancer	Yes	No	Coagulopathy/Clotting disorder	Yes	No
Diabetes	Yes	No	Kidney disease	Yes	No	Thyroid disease	Yes	No

Other Past Medical History not listed: \_\_\_\_\_

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**Surgical History**

**Please list any surgeries that you have had in the past. Some of the more common ones are listed below**

**Please circle and date if relevant:**

Amputation site _____ Date of surgery _____	Aneurysm repair/site _____ Date of surgery _____
Bladder/Prostate repair/ Date of surgery _____	Carotid surgery/ Date of surgery _____
Cataract/ Date of surgery _____	Heart stent/bypass/ Date of surgery _____
Laparoscopy (abdominal scope)/ Date of surgery _____	Lower extremity bypass/Date of surgery _____
Pacemaker / Date of implant _____	Prostate repair/Date of surgery _____
Orthopedic surgeries (Knee, shoulder/rotator cuff, hip replacement) Date of surgery _____	
Other surgeries or procedures _____	

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**Social History**

**(Circle all that apply)**

Do you drink alcohol?    Current everyday    Current someday    Former    Never    Unknown

Beer/Wine/Liquor How many per week? \_\_\_\_\_

Do you use recreational Drugs?    Current everyday    Current someday    Former    Never    Unknown

Have you ever used tobacco?    Current everyday    Current someday    Former    Never    Unknown

How many packs per day do you or did you smoke?    Less than half    Half    One    One and half    Other \_\_\_\_\_

How many years did you or have you smoked? \_\_\_\_\_ When did you quit? \_\_\_\_\_

**Family History- Please list which family member was affected**

Mother, Father, Brother, Sister, Grandmother (maternal/paternal) Grandfather (maternal/paternal)

Abdominal aortic aneurysm \_\_\_\_\_ Heart Disease \_\_\_\_\_

Bleeding Disorder \_\_\_\_\_ High Blood Pressure \_\_\_\_\_

Blood Clots \_\_\_\_\_ High Cholesterol \_\_\_\_\_

Cancer \_\_\_\_\_ Type \_\_\_\_\_ Stroke \_\_\_\_\_

Diabetes \_\_\_\_\_

**Current Medications and Allergies**

ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS?

Plavix/Clopidogrel: Dose/Frequency \_\_\_\_\_ Reason \_\_\_\_\_

Coumadin/Warfarin: Dose/Frequency \_\_\_\_\_ Reason \_\_\_\_\_

Aspirin Dose/Frequency \_\_\_\_\_ Reason \_\_\_\_\_

Please list the Provider that is monitoring any of the above medications: \_\_\_\_\_

Do you have any known Allergies to Medications? Please Mark Box if None: ☐

Iodine? Reaction \_\_\_\_\_ Latex? ☐ Reaction \_\_\_\_\_

Others? Please list Medication and Reaction \_\_\_\_\_

**Please list all medications that you are currently taking (including insulin, over-the-counter medications, vitamins, diet supplements, herbal preparations, etc.).**

Medication/Reason Dosage/Frequency Medication/Frequency

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Exercise:**

Do you exercise regularly? ☐ No ☐ Yes If yes, what kind of exercise? \_\_\_\_\_

How long (minutes)? \_\_\_\_\_ How often? \_\_\_\_\_

Sexual Relations Status? ☐ No Change ☐ Not applicable ☐ Painful/limited ☐ Unable due to pain

☐ Decreased desire ☐ Lack of Desire

Are you pregnant? ☐ Yes How many weeks? \_\_\_\_\_ ☐ No

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

## 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. Pupil's 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. Reducc confidence
- m Apathy
- nn. Irritability
- oo. Sleepiness
- pp. Frustration
- qq. Impatience
- rr. Other head related issues

#### 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

Shoulder pain LEFT RIGHT BOTH

- c. Shoulder pain with movement
- e. Shoulder spasms
- f. Sharp shoulder pain
- g. Dull shoulder pain
- h. Achy shoulder pain
- g. Pins and needles shoulder pain
- h. Shoulder pain that radiates or shoots pain into arm
- i. Other:

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

6. UPPER ARM PAIN: RIGHT LEFT BOTH

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

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

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

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

9. WRIST PAIN: RIGHT LEFT BOTH

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

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

- c. Sacral pain (tail bone)
- d. Coccygeal or coccyx (tail bone) pain

21. OTHER SYMPTOMS:

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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 YES NO

20. STOMACH PAIN YES NO

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

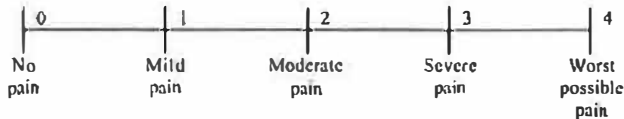
\_\_\_\_\_  
Date

# Functional Rating Index

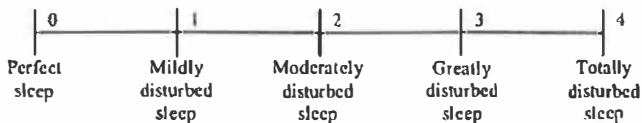
For use with Neck and/or Back Problems only.

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.**

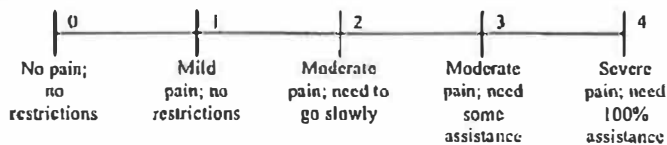
## 1. Pain Intensity



## 2. Sleeping



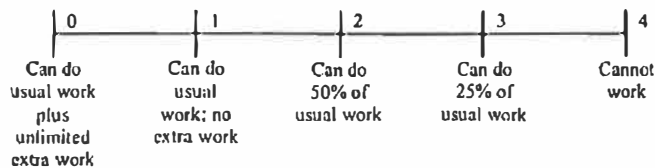
## 3. Personal Care (washing, dressing, etc.)



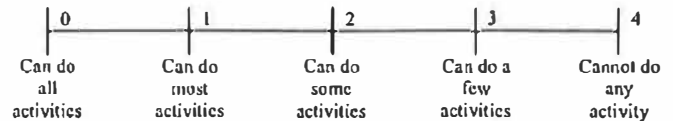
## 4. Travelling (driving, etc.)



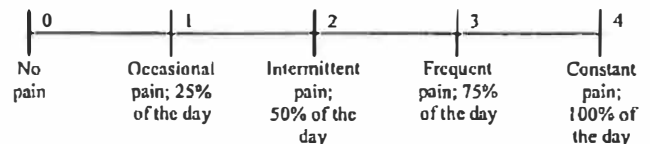
## 5. Work



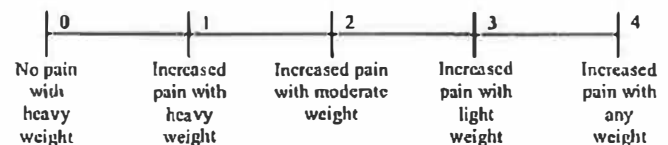
## 6. Recreation



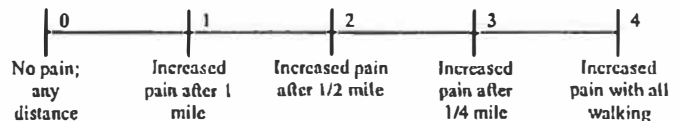
## 7. Frequency of Pain



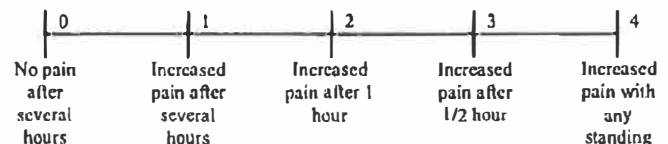
## 8. Lifting



## 9. Walking



## 10. Standing



**Patient's Signature**

**Date**

### For Office Use Only:

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

Clinical Diagnosis Codes:

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