

WRITE LEGIBLY

# WC/PI SUBJECTIVE COMPLAINTS

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PAYMENT is due at the time of service, unless other arrangements have been made.

Patients involved in LITIGATION (law suits) are responsible for their services here at the clinic.

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT I HAVE READ THE ABOVE POLICIES AND AGREE TO ABIDE BY SAME.

PATIENT SIGNATURE \_\_\_\_\_

WITNESS \_\_\_\_\_

GUARDIAN SIGNATURE \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

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

Male  Female Birthdate \_\_\_\_\_

Street/P.O. Box \_\_\_\_\_

Age \_\_\_\_\_ Height: \_\_\_\_\_" Weight \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ Driver's License # \_\_\_\_\_

Who referred you to our clinic? \_\_\_\_\_

Emergency Name/Phone: \_\_\_\_\_

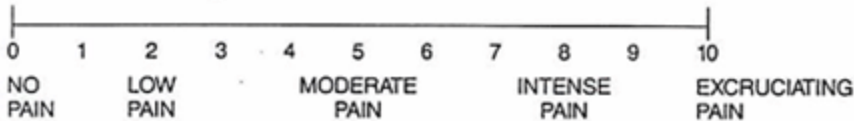
10. DESCRIBE COMPLAINTS: PLEASE BE SPECIFIC

a) Involving Neck & Head: \_\_\_\_\_

b) Involving Mid-back / Shoulders / Arms & Hands: \_\_\_\_\_

c) Involving Low Back / Hips / Legs & Feet: \_\_\_\_\_

20. PAIN LEVEL: On a scale of 0-10, with 0 being you're pain free and can function quite well, and 10 being you're in pain all the time cannot function at all, where would you rate yourself?



30. WHAT ACTIVITIES MAKES CONDITION WORSE? \_\_\_\_\_

40. WHAT ACTIVITIES MAKES CONDITION BETTER? \_\_\_\_\_

50-80. INDICATE ABILITY TO PERFORM THE FOLLOWING ACTIVITIES:

USE CODES: U=Unable/50 P=Painful/60 D=Difficult/70  
L=Limited/70 N=Normal/80

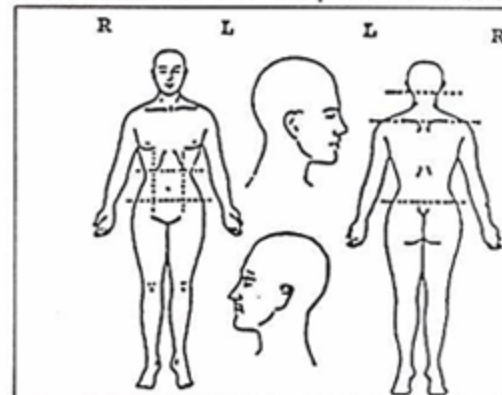
- |   |  |
|---|--|
| <input type="checkbox"/> Coughing or sneezing           | <input type="checkbox"/> Climbing        |
| <input type="checkbox"/> Getting in or out of a car     | <input type="checkbox"/> Kneeling        |
| <input type="checkbox"/> Bending forward to brush teeth | <input type="checkbox"/> Balancing       |
| <input type="checkbox"/> Turning over in bed            | <input type="checkbox"/> Dressing self   |
| <input type="checkbox"/> Walking short distances        | <input type="checkbox"/> Sleeping        |
| <input type="checkbox"/> Standing for more than 1 hour  | <input type="checkbox"/> Stooping        |
| <input type="checkbox"/> Sitting at a table             | <input type="checkbox"/> Gripping        |
| <input type="checkbox"/> Lying on back                  | <input type="checkbox"/> Pushing         |
| <input type="checkbox"/> Lying flat on stomach          | <input type="checkbox"/> Pulling         |
| <input type="checkbox"/> Lying on side with knees bent  | <input type="checkbox"/> Reaching        |
| <input type="checkbox"/> Bending over forward           | <input type="checkbox"/> Sexual activity |

130-140. FAMILY HISTORY: (for example: Cancer / Diabetes / Heart problems / Back or neck problems)

Father: \_\_\_\_\_ Brother/Brothers: \_\_\_\_\_  
Mother: \_\_\_\_\_ Sister/Sisters: \_\_\_\_\_

150. SHADE AND CODE AREA(S) TO INDICATE LOCATION OF PAIN OR DISCOMFORT:

USE CODES:  
P = Pain N = Numbness S = Spasm T = Tenderness:



90. CHECK YOUR NERVOUS SYSTEM COMPLAINTS

- |  |   |
|--|---|
| <input type="checkbox"/> Blurring vision             | <input type="checkbox"/> Headaches                              |
| <input type="checkbox"/> Buzzing or ringing in ears  | <input type="checkbox"/> How often do you have headaches? _____ |
| <input type="checkbox"/> Confusion                   | <input type="checkbox"/> Loss of sleep                          |
| <input type="checkbox"/> Convulsions                 | <input type="checkbox"/> Low resistance                         |
| <input type="checkbox"/> Depression or crying spells | <input type="checkbox"/> Muscle jerking                         |
| <input type="checkbox"/> Dizziness                   | <input type="checkbox"/> Numbness                               |
| <input type="checkbox"/> Fainting                    |   |
| <input type="checkbox"/> Paralysis                   |   |

CHECK PROPER SPACE:

100. Symptoms are BETTER in:  AM  Midday  PM

110. Symptoms are WORSE in:  AM  Midday  PM

120.  Symptoms do not change with time of day

160. (WOMEN ONLY) Are you pregnant?  Yes  No

Date of onset of last menstrual cycle \_\_\_\_\_

170. Give date of last X-rays: \_\_\_\_\_

Name \_\_\_\_\_

Date \_\_\_\_\_ File# \_\_\_\_\_

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## PERSONAL INJURY PATIENT HISTORY

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Name \_\_\_\_\_ Date \_\_\_\_\_ File# \_\_\_\_\_

### 30 HISTORY OF OCCURENCE

10 Date of Accident: \_\_\_\_\_ Time: \_\_\_\_\_  AM  PM

Driver of car: \_\_\_\_\_ What seat were you sitting in? \_\_\_\_\_

Who owns the car? \_\_\_\_\_ Year and model of car: \_\_\_\_\_

What was the approximate damage done to the car you were in? \$ \_\_\_\_\_

20 Visibility at time of accident:  Poor  Fair  Good

Road conditions at time of accident:  Icy  Rainy and  Wet  Clear  Dark

Your car:  Hit another car  Was hit in the:  Right  Left  Rear  Front  Side.

Type of accident:  Head-on collision  Broad side-collision

Rear-end collision  Front impact, rear-ended car in front

Non-collision: \_\_\_\_\_

### 40 IMPACT/SEAT BELT/HEADREST/SPEED

10 Describe in your own words what happened to you upon impact: \_\_\_\_\_

Did you see the accident coming?  Yes  No

Were you prewarned that the accident was about to happen?  Yes  No

Did you brace for the impact?  Yes  No

Were seat belts worn?  Yes  No

Were shoulder harnesses worn?  Yes  No

20 Does your car have headrests?  No

30 If yes, what was the position of those headrests compared to your head before the accident?

Top of headrest even with bottom of head  Top of headrest even with top of head  Top of headrest even with middle of neck

40 Was your car braking?  Yes  No

50 Was your car moving at the time of accident?  Yes  No

60 If yes, how fast would you estimate you were going? \_\_\_\_\_ MPH (estimate)

70 How fast was the other car travelling? \_\_\_\_\_ MPH (estimate)

### 50 HEAD/BODY POSITION/ABLE TO MOVE BODY

10 Head/Body position at time of impact:  Head turned:  Right  Left  Head looking back  Head straight forward

Body straight in sitting position  Body rotated:  Right  Left

20 At the time of accident, recall what parts of your head or body hit what parts on the inside of your car: \_\_\_\_\_

30 As a result of the accident you were:  Rendered unconscious  Dazed, circumstances vague  Shaken up but could function

40 Could you move all parts of your body?  Yes

50 If no, what body parts could you not move and why? \_\_\_\_\_

60 Were you able to get out of the car and walk unaided?  Yes

70 If no, why couldn't you get out of the car and walk unaided? \_\_\_\_\_

**60 SYMPTOMS FROM ACCIDENT**

10 Did you get bleeding cuts or bruises?  No

20 If yes, what bleeding cuts did you get from this accident? \_\_\_\_\_

If yes, what bruises did you get from this accident? \_\_\_\_\_

30 Please describe how you felt. *PLEASE BE SPECIFIC.*

Immediately after the accident: \_\_\_\_\_

40 Later that  Day  Night: \_\_\_\_\_

50 The next day(s): \_\_\_\_\_

60 Check symptoms apparent since the accident:

- |  |   |  |  |                                       |
|--|---|--|--|---------------------------------------|
| <input type="checkbox"/> Headache                | <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Loss of memory      | <input type="checkbox"/> Sleeping problems   | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Neck pain/stiffness     | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Numbness in toes    | <input type="checkbox"/> Chest pain   |
| <input type="checkbox"/> Midback pain            | <input type="checkbox"/> Ringing/buzzing ears | <input type="checkbox"/> Tension             | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Nervousness  |
| <input type="checkbox"/> Low back pain           | <input type="checkbox"/> Loss of balance      | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Cold hands          | <input type="checkbox"/> Cold sweats  |
| <input type="checkbox"/> Eyes sensitive to light | <input type="checkbox"/> Loss of smell        | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Cold feet           | <input type="checkbox"/> Anxious      |
| <input type="checkbox"/> Pain behind eyes        | <input type="checkbox"/> Loss of taste        | <input type="checkbox"/> Depression          | <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Other _____  |

**70 WORK STATUS HISTORY**

10 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

20 Have you missed time from work?  Yes  No

30-40 If Yes: Full time off work \_\_\_\_\_

50 If Yes: Part-time off work \_\_\_\_\_

60  Been unable to work since accident.

**80 FIRST DOCTOR/HOSPITAL/CLINIC SEEN**

10 Did you go to seek medical help immediately/soon after the accident?  Yes  No

If yes, how did you get there?  Someone else drove me  Drove own car  Ambulance  Police

DOCTOR 1/HOSPITAL/CLINIC SEEN: \_\_\_\_\_ Date of first visit: \_\_\_\_\_

20 Were you examined?  Yes  No Were X-rays taken?  Yes  No

30 Were you given treatment?  No

40 If yes, what treatment was given to you? \_\_\_\_\_

What benefits did you receive from the treatment? \_\_\_\_\_

50 Date of last treatment: \_\_\_\_\_

**90 SECOND DOCTOR/CLINIC SEEN**

10 DOCTOR 2/CLINIC SEEN: \_\_\_\_\_ Date of first visit: \_\_\_\_\_

Were you examined?  Yes  No Were X-rays taken?  Yes  No

20 Were you given treatment?  No

30 If yes, what treatment was given to you? \_\_\_\_\_

What benefits did you receive from the treatment? \_\_\_\_\_

40 Date of last treatment: \_\_\_\_\_

**100 THIRD DOCTOR CLINIC SEEN**

10 DOCTOR 3/CLINIC SEEN: \_\_\_\_\_ Date of first visit: \_\_\_\_\_

Were you examined?  Yes  No Were X-rays taken?  Yes  No

20 Were you given treatment?  No

30 If yes, what treatment was given to you? \_\_\_\_\_

What benefits did you receive from the treatment? \_\_\_\_\_

40 Date of last treatment: \_\_\_\_\_

**110 PRIOR SIMILAR SYMPTOMS**

10 Did you have any physical complaints just before the accident?  No

20 If yes, what physical symptoms did you have just before the accident? \_\_\_\_\_

30 PRIOR to this accident, have you EVER had symptoms similar to what you're experiencing now?  No

40 If yes, please explain (briefly include past falls, injuries, accidents, operations, etc.): \_\_\_\_\_

**120 ACTIVITIES OF DAILY LIVING**

10 Do you notice any activities of your home daily routines that are different now than from before the accident?  No

20 If yes, list them as:

30 Those activities that you are now unable to do are (be specific): \_\_\_\_\_

40 Those activities that are now painful to do are (be specific): \_\_\_\_\_

50 Those activities that are now difficult to do are (be specific): \_\_\_\_\_

**INDICATE ON THESE DIAGRAMMS HOW THE ACCIDENT HAPPENED**



**ATTORNEY ON CASE**

Do you have an attorney on this case?  No

If yes, who? Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

**AUTOMOBILE ACCIDENT — INSURANCE DATA**

**Patient's Insurance Company Information**

Company Name: \_\_\_\_\_ PH: \_\_\_\_\_ Policy #: \_\_\_\_\_

P.O. Box/Street Number: \_\_\_\_\_ Adjuster's Name: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

**Insured's Insurance Information**

Insured's name if other than patient: \_\_\_\_\_ PH: \_\_\_\_\_

Company Name: \_\_\_\_\_ PH: \_\_\_\_\_ Policy #: \_\_\_\_\_

P.O. Box/Street Number: \_\_\_\_\_ Adjuster's Name: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

**Other Driver's Insurance Information**

Other Driver's Name (if another car was involved): \_\_\_\_\_ PH: \_\_\_\_\_

Company Name: \_\_\_\_\_ PH: \_\_\_\_\_ Policy #: \_\_\_\_\_

P.O. Box/Street Number: \_\_\_\_\_ Adjuster's Name: \_\_\_\_\_