

Winters® Chiropractic & Physical Therapy

REGISTRATION AND HISTORY

PATIENT INFORMATION

Preferred Name _____ Date _____

Patient Name _____
Last First MI

Address _____
City State Zip

Email _____

Sex: M F Age _____ Birth Date _____

Dominant Hand: L R Both

Single Married Widowed Separated Divorced

Patient SS# _____

Occupation _____

Employer _____

Spouse's Name _____

Birth Date _____ Occupation _____

Primary MD _____

Clinic Name/Phone _____

Do you give us permission to release your clinical records/status to your primary MD? Yes No

PHONE NUMBERS

Home _____ Cell _____

Work _____ Ext _____

Best time and place to reach you _____

Emergency Contact Name _____

Relationship _____

Best number(s) to contact them _____

HEALTH HISTORY

Prior Injuries/Surgeries

Description

Date

Falls _____

Head injuries _____

Broken bones _____

Dislocations _____

Surgeries _____

INSURANCE AND ATTORNEY INFORMATION

Date of Injury _____

Is a claim filed with the Workers' Comp. Company? Yes No

Workers' Comp. Co. Name _____

Claim # _____

Adjustor/Contact Name _____

Adjustor/Contact Phone # _____

Do you have an Attorney? Yes No

Name of Attorney _____

Contact Name _____

Contact Phone # _____

Do you have Health Insurance? Yes No

If yes, name of Health Ins. Co. _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with:

Workers' Comp. Co. _____

Name of Attorney _____

Name of Health Ins. Co. _____

and assigns directly to Winters Chiropractic & Physical Therapy, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Date

<p>General</p> <ul style="list-style-type: none"> <input type="checkbox"/> bruise easily <input type="checkbox"/> chills <input type="checkbox"/> dental problems <input type="checkbox"/> depression <input type="checkbox"/> difficulty sleeping <input type="checkbox"/> dizziness <input type="checkbox"/> fainting <input type="checkbox"/> fever <input type="checkbox"/> forgetfulness <input type="checkbox"/> headache <input type="checkbox"/> loss of sleep <input type="checkbox"/> loss of weight <input type="checkbox"/> nervousness <input type="checkbox"/> numbness <input type="checkbox"/> sweats <input type="checkbox"/> tiredness <input type="checkbox"/> weight gain 	<p>Gastrointestinal</p> <ul style="list-style-type: none"> <input type="checkbox"/> appetite poor <input type="checkbox"/> bloating <input type="checkbox"/> bowel changes <input type="checkbox"/> constipation <input type="checkbox"/> diarrhea <input type="checkbox"/> excessive hunger <input type="checkbox"/> excessive thirst <input type="checkbox"/> gas <input type="checkbox"/> hemorrhoids <input type="checkbox"/> indigestion <input type="checkbox"/> nausea <input type="checkbox"/> rectal bleeding <input type="checkbox"/> stomach pain <input type="checkbox"/> vomiting <input type="checkbox"/> vomiting blood 	<p>Eye, Ear, Nose, Throat</p> <ul style="list-style-type: none"> <input type="checkbox"/> bleeding gums <input type="checkbox"/> blurred vision <input type="checkbox"/> crossed eyes <input type="checkbox"/> difficulty swallowing <input type="checkbox"/> double vision <input type="checkbox"/> earache <input type="checkbox"/> ear discharge <input type="checkbox"/> hay fever <input type="checkbox"/> hoarseness <input type="checkbox"/> loss of hearing <input type="checkbox"/> nose bleeds <input type="checkbox"/> persistent cough <input type="checkbox"/> ring in ears <input type="checkbox"/> sinus problems <input type="checkbox"/> vision-flashes <input type="checkbox"/> vision-halos 	<p>Genito-Urinary</p> <ul style="list-style-type: none"> <input type="checkbox"/> blood in urine <input type="checkbox"/> frequent urination <input type="checkbox"/> lack of bladder control <input type="checkbox"/> painful urination <p>Skin</p> <ul style="list-style-type: none"> <input type="checkbox"/> bruise easily <input type="checkbox"/> hives <input type="checkbox"/> itching <input type="checkbox"/> changes in moles <input type="checkbox"/> rash <input type="checkbox"/> scars <input type="checkbox"/> sore that won't heal 				
<p>Cardiovascular</p> <ul style="list-style-type: none"> <input type="checkbox"/> chest pain <input type="checkbox"/> high blood pressure <input type="checkbox"/> irregular heart beat <input type="checkbox"/> low blood pressure <input type="checkbox"/> poor circulation <input type="checkbox"/> rapid heart beat <input type="checkbox"/> swelling of ankles <input type="checkbox"/> varicose veins 	<p>Men Only</p> <ul style="list-style-type: none"> <input type="checkbox"/> breast lump <input type="checkbox"/> erection difficulties <input type="checkbox"/> lump in testicles <input type="checkbox"/> penis discharge <input type="checkbox"/> sore on penis 	<p>Women Only</p> <ul style="list-style-type: none"> <input type="checkbox"/> abnormal pap smear <input type="checkbox"/> bleeding between <input type="checkbox"/> period <input type="checkbox"/> breast lump <input type="checkbox"/> extreme menstrual pain <p>Date of last menstruation _____</p> <p>Date of last pap smear _____</p> <ul style="list-style-type: none"> <input type="checkbox"/> hot flashes <input type="checkbox"/> nipple discharge <input type="checkbox"/> painful intercourse <input type="checkbox"/> vaginal discharge <p>Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Number of children _____</p> <p>Have you had a mammogram? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
<p>Exercise _____ hrs/wk</p> <ul style="list-style-type: none"> <input type="checkbox"/> none <input type="checkbox"/> moderate <input type="checkbox"/> daily <input type="checkbox"/> heavy 	<p>Work Activity</p> <ul style="list-style-type: none"> <input type="checkbox"/> sitting <input type="checkbox"/> standing <input type="checkbox"/> light labor <input type="checkbox"/> heavy labor 	<p>Habits</p> <ul style="list-style-type: none"> <input type="checkbox"/> smoking _____ packs/day <input type="checkbox"/> alcohol _____ drinks/week <input type="checkbox"/> coffee/caffeine drinks _____ cups/day <input type="checkbox"/> high stress level Reason _____ 					
<p style="text-align: center;">CONDITIONS check current and past conditions.</p> <table border="0" style="width: 100%;"> <tr> <td style="vertical-align: top; width: 25%;"> <ul style="list-style-type: none"> <input type="checkbox"/> AIDS <input type="checkbox"/> alcoholism <input type="checkbox"/> anemia <input type="checkbox"/> anorexia <input type="checkbox"/> appendicitis <input type="checkbox"/> arthritis <input type="checkbox"/> asthma <input type="checkbox"/> bleeding disorders <input type="checkbox"/> breast lump <input type="checkbox"/> bronchitis <input type="checkbox"/> bulimia <input type="checkbox"/> cancer <input type="checkbox"/> cataracts <input type="checkbox"/> chemical dependency <input type="checkbox"/> chicken pox </td> <td style="vertical-align: top; width: 25%;"> <ul style="list-style-type: none"> <input type="checkbox"/> diabetes <input type="checkbox"/> emphysema <input type="checkbox"/> epilepsy <input type="checkbox"/> fractures <input type="checkbox"/> glaucoma <input type="checkbox"/> goiter <input type="checkbox"/> gonorrhea <input type="checkbox"/> gout <input type="checkbox"/> heart disease <input type="checkbox"/> hepatitis <input type="checkbox"/> hernia <input type="checkbox"/> herpes <input type="checkbox"/> high cholesterol <input type="checkbox"/> HIV positive <input type="checkbox"/> kidney disease </td> <td style="vertical-align: top; width: 25%;"> <ul style="list-style-type: none"> <input type="checkbox"/> liver disease <input type="checkbox"/> measles <input type="checkbox"/> migraine headaches <input type="checkbox"/> miscarriage <input type="checkbox"/> mononucleosis <input type="checkbox"/> multiple sclerosis <input type="checkbox"/> mumps <input type="checkbox"/> osteoporosis <input type="checkbox"/> pacemaker <input type="checkbox"/> pneumonia <input type="checkbox"/> polio <input type="checkbox"/> prostate <input type="checkbox"/> prosthesis <input type="checkbox"/> psychiatric disorder <input type="checkbox"/> rheumatoid arthritis </td> <td style="vertical-align: top; width: 25%;"> <ul style="list-style-type: none"> <input type="checkbox"/> rheumatic fever <input type="checkbox"/> scarlet fever <input type="checkbox"/> stroke <input type="checkbox"/> suicide attempt <input type="checkbox"/> thyroid problems <input type="checkbox"/> tonsillitis <input type="checkbox"/> tuberculosis <input type="checkbox"/> tumors, growths <input type="checkbox"/> typhoid fever <input type="checkbox"/> ulcers <input type="checkbox"/> vaginal infections <input type="checkbox"/> venereal disease <input type="checkbox"/> whopping cough <input type="checkbox"/> other _____ </td> </tr> </table> <p>Medications _____</p>				<ul style="list-style-type: none"> <input type="checkbox"/> AIDS <input type="checkbox"/> alcoholism <input type="checkbox"/> anemia <input type="checkbox"/> anorexia <input type="checkbox"/> appendicitis <input type="checkbox"/> arthritis <input type="checkbox"/> asthma <input type="checkbox"/> bleeding disorders <input type="checkbox"/> breast lump <input type="checkbox"/> bronchitis <input type="checkbox"/> bulimia <input type="checkbox"/> cancer <input type="checkbox"/> cataracts <input type="checkbox"/> chemical dependency <input type="checkbox"/> chicken pox 	<ul style="list-style-type: none"> <input type="checkbox"/> diabetes <input type="checkbox"/> emphysema <input type="checkbox"/> epilepsy <input type="checkbox"/> fractures <input type="checkbox"/> glaucoma <input type="checkbox"/> goiter <input type="checkbox"/> gonorrhea <input type="checkbox"/> gout <input type="checkbox"/> heart disease <input type="checkbox"/> hepatitis <input type="checkbox"/> hernia <input type="checkbox"/> herpes <input type="checkbox"/> high cholesterol <input type="checkbox"/> HIV positive <input type="checkbox"/> kidney disease 	<ul style="list-style-type: none"> <input type="checkbox"/> liver disease <input type="checkbox"/> measles <input type="checkbox"/> migraine headaches <input type="checkbox"/> miscarriage <input type="checkbox"/> mononucleosis <input type="checkbox"/> multiple sclerosis <input type="checkbox"/> mumps <input type="checkbox"/> osteoporosis <input type="checkbox"/> pacemaker <input type="checkbox"/> pneumonia <input type="checkbox"/> polio <input type="checkbox"/> prostate <input type="checkbox"/> prosthesis <input type="checkbox"/> psychiatric disorder <input type="checkbox"/> rheumatoid arthritis 	<ul style="list-style-type: none"> <input type="checkbox"/> rheumatic fever <input type="checkbox"/> scarlet fever <input type="checkbox"/> stroke <input type="checkbox"/> suicide attempt <input type="checkbox"/> thyroid problems <input type="checkbox"/> tonsillitis <input type="checkbox"/> tuberculosis <input type="checkbox"/> tumors, growths <input type="checkbox"/> typhoid fever <input type="checkbox"/> ulcers <input type="checkbox"/> vaginal infections <input type="checkbox"/> venereal disease <input type="checkbox"/> whopping cough <input type="checkbox"/> other _____
<ul style="list-style-type: none"> <input type="checkbox"/> AIDS <input type="checkbox"/> alcoholism <input type="checkbox"/> anemia <input type="checkbox"/> anorexia <input type="checkbox"/> appendicitis <input type="checkbox"/> arthritis <input type="checkbox"/> asthma <input type="checkbox"/> bleeding disorders <input type="checkbox"/> breast lump <input type="checkbox"/> bronchitis <input type="checkbox"/> bulimia <input type="checkbox"/> cancer <input type="checkbox"/> cataracts <input type="checkbox"/> chemical dependency <input type="checkbox"/> chicken pox 	<ul style="list-style-type: none"> <input type="checkbox"/> diabetes <input type="checkbox"/> emphysema <input type="checkbox"/> epilepsy <input type="checkbox"/> fractures <input type="checkbox"/> glaucoma <input type="checkbox"/> goiter <input type="checkbox"/> gonorrhea <input type="checkbox"/> gout <input type="checkbox"/> heart disease <input type="checkbox"/> hepatitis <input type="checkbox"/> hernia <input type="checkbox"/> herpes <input type="checkbox"/> high cholesterol <input type="checkbox"/> HIV positive <input type="checkbox"/> kidney disease 	<ul style="list-style-type: none"> <input type="checkbox"/> liver disease <input type="checkbox"/> measles <input type="checkbox"/> migraine headaches <input type="checkbox"/> miscarriage <input type="checkbox"/> mononucleosis <input type="checkbox"/> multiple sclerosis <input type="checkbox"/> mumps <input type="checkbox"/> osteoporosis <input type="checkbox"/> pacemaker <input type="checkbox"/> pneumonia <input type="checkbox"/> polio <input type="checkbox"/> prostate <input type="checkbox"/> prosthesis <input type="checkbox"/> psychiatric disorder <input type="checkbox"/> rheumatoid arthritis 	<ul style="list-style-type: none"> <input type="checkbox"/> rheumatic fever <input type="checkbox"/> scarlet fever <input type="checkbox"/> stroke <input type="checkbox"/> suicide attempt <input type="checkbox"/> thyroid problems <input type="checkbox"/> tonsillitis <input type="checkbox"/> tuberculosis <input type="checkbox"/> tumors, growths <input type="checkbox"/> typhoid fever <input type="checkbox"/> ulcers <input type="checkbox"/> vaginal infections <input type="checkbox"/> venereal disease <input type="checkbox"/> whopping cough <input type="checkbox"/> other _____ 				

ONLY NEED TO COMPLETE THIS PAGE IF INJURY WAS DUE TO A WORK RELATED AUTO ACCIDENT

Your Vehicle Type: <input type="checkbox"/> Car <input type="checkbox"/> S.U.V. <input type="checkbox"/> Van <input type="checkbox"/> Bus <input type="checkbox"/> Large Truck <input type="checkbox"/> Pickup Truck <input type="checkbox"/> Other _____	Your Position in Vehicle: <input type="checkbox"/> Driver <input type="checkbox"/> Front passenger <input type="checkbox"/> Left rear passenger <input type="checkbox"/> Right rear passenger <input type="checkbox"/> Other _____	Time/Speed/Damage: Accident Time _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Your vehicle's speed _____ mph Their vehicle's speed _____ mph Damage to your vehicle: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Totaled
What was your vehicle doing at the time of the accident: <input type="checkbox"/> stopped at intersection <input type="checkbox"/> stopped in traffic <input type="checkbox"/> stopped at light <input type="checkbox"/> making a right turn <input type="checkbox"/> making a left turn <input type="checkbox"/> stopped at intersection <input type="checkbox"/> proceeding along <input type="checkbox"/> stopped at intersection <input type="checkbox"/> stopped at intersection		Visibility at the time: <input type="checkbox"/> good <input type="checkbox"/> fair <input type="checkbox"/> poor
Road conditions at the time of the accident: <input type="checkbox"/> icy <input type="checkbox"/> wet <input type="checkbox"/> sandy <input type="checkbox"/> dark <input type="checkbox"/> clean and dry		Who hit who/what? <input type="checkbox"/> you hit other vehicle <input type="checkbox"/> other vehicle hit you <input type="checkbox"/> you hit...(write object below) _____
Road conditions at the time of the accident: <input type="checkbox"/> head-on <input type="checkbox"/> rear-end <input type="checkbox"/> left front <input type="checkbox"/> right front <input type="checkbox"/> left rear <input type="checkbox"/> right rear		Headrest position? <input type="checkbox"/> even with top of head <input type="checkbox"/> even with bottom of head <input type="checkbox"/> middle of neck
Body position, ect. Did you see the accident coming? <input type="checkbox"/> Yes <input type="checkbox"/> No Were you braced for the impact? <input type="checkbox"/> Yes <input type="checkbox"/> No Were you wearing your seatbelt? <input type="checkbox"/> Yes <input type="checkbox"/> No Did you have your shoulder harness on? <input type="checkbox"/> Yes <input type="checkbox"/> No Did the driver's forward airbag deploy? <input type="checkbox"/> Yes <input type="checkbox"/> No Did passenger's forward airbag deploy? <input type="checkbox"/> Yes <input type="checkbox"/> No Did the side airbags deploy? <input type="checkbox"/> Yes <input type="checkbox"/> No Does your vehicle have headrests? <input type="checkbox"/> Yes <input type="checkbox"/> No		What was the direction of the head at the time of impact? <input type="checkbox"/> facing straight forward <input type="checkbox"/> turned to the right <input type="checkbox"/> turned to the left
During the accident: Did your body strike the inside of your vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe _____ _____ Did you lose consciousness during the injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe _____ _____		
Your vehicles estimated damage: \$ _____		Did the police show up at the scene? <input type="checkbox"/> Yes <input type="checkbox"/> No
Damage to their vehicle: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Totaled		Was an accident report filled out? <input type="checkbox"/> Yes <input type="checkbox"/> No

SYMPTOMS: CHOOSE ONE SYMPTOM FOR EACH PAGE

(There are 3 pages for symptoms and more can be printed if needed)

1st WORST Current Symptom

Please choose **ONE** symptom from the list below and complete this page for that symptom.

Symptom #1 _____

- | | | |
|--------------------------------|-----------|------------|
| Low Back | Mid Back | Upper Back |
| Neck | Upper Arm | Shoulder |
| Head (front) | Chest | Abdomen |
| Head (top) | Ribs | Buttocks |
| Head (sides) | Forearm | Hand |
| Head (back) | Leg | Hip |
| Foot | Jaw | Eye |
| Other Location (specify) _____ | | |

Location of Pain:

- Left Right Both

Pain Scale (circle):



Does this pain radiate into other body parts?

- Yes No

- | | Left | Right | Both |
|-------------|--------------------------|--------------------------|--------------------------|
| Head | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Neck | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Shoulder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Arm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hand | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hip | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Leg | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Foot | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____ | | | |

Type of Pain (mark all that apply):

- | | |
|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Dull | <input type="checkbox"/> Numbing |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Spasm | <input type="checkbox"/> Cutting |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Pounding |
| <input type="checkbox"/> Stinging | <input type="checkbox"/> Cramping |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Constricting |

Pain Frequency:

- Up to ¼ of awake time
 Up to ¼ to ½ of awake time
 Up to ½ to ¾ of awake time
 Most all of the time

Pain Intensity (how it affects your daily activities):

- Doesn't affect
 Somewhat affects
 Seriously affects
 Prevents activities

Actions Affecting This Pain:

- | | Brings on | Aggravates | Relieves |
|-----------------|--------------------------|--------------------------|--------------------------|
| In the A.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| In the P.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bending forward | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bending back | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bending left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bending right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Twisting left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Twisting right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Coughing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sneezing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Straining | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Standing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lifting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

SYMPTOMS: CHOOSE ONE SYMPTOM FOR EACH PAGE

(There are 3 pages for symptoms and more can be printed if needed)

2nd Current Symptom

Please choose **ONE** symptom from the list below and complete this page for that symptom.

Symptom #2

- | | | |
|--------------------------|-----------|------------|
| Low Back | Mid Back | Upper Back |
| Neck | Upper Arm | Shoulder |
| Head (front) | Chest | Abdomen |
| Head (top) | Ribs | Buttocks |
| Head (sides) | Forearm | Hand |
| Head (back) | Leg | Hip |
| Foot | Jaw | Eye |
| Other Location (specify) | | |

Location of Pain:

- Left Right Both

Pain Scale (circle):



Does this pain radiate into other body parts?

- Yes No

- | | Left | Right | Both |
|----------|--------------------------|--------------------------|--------------------------|
| Head | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Neck | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Shoulder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Arm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hand | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hip | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Leg | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Foot | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | | | |

Type of Pain (mark all that apply):

- | | |
|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Dull | <input type="checkbox"/> Numbing |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Spasm | <input type="checkbox"/> Cutting |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Pounding |
| <input type="checkbox"/> Stinging | <input type="checkbox"/> Cramping |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Constricting |

Pain Frequency:

- Up to 1/4 of awake time
 Up to 1/4 to 1/2 of awake time
 Up to 1/2 to 3/4 of awake time
 Most all of the time

Pain Intensity (how it affects your daily activities):

- Doesn't affect
 Somewhat affects
 Seriously affects
 Prevents activities

Actions Affecting This Pain:

- | | Brings on | Aggravates | Relieves |
|-----------------|--------------------------|--------------------------|--------------------------|
| In the A.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| In the P.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bending forward | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bending back | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bending left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bending right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Twisting left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Twisting right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Coughing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sneezing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Straining | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Standing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lifting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

SYMPTOMS: CHOOSE ONE SYMPTOM FOR EACH PAGE

(There are 3 pages for symptoms and more can be printed if needed)

3rd Current Symptom

Please choose **ONE** symptom from the list below and complete this page for that symptom.

Symptom #3

- | | | |
|--------------------------------|-----------|------------|
| Low Back | Mid Back | Upper Back |
| Neck | Upper Arm | Shoulder |
| Head (front) | Chest | Abdomen |
| Head (top) | Ribs | Buttocks |
| Head (sides) | Forearm | Hand |
| Head (back) | Leg | Hip |
| Foot | Jaw | Eye |
| Other Location (specify) _____ | | |

Location of Pain:

- Left Right Both

Pain Scale (circle):



Does this pain radiate into other body parts?

- Yes No

- | | Left | Right | Both |
|-------------|--------------------------|--------------------------|--------------------------|
| Head | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Neck | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Shoulder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Arm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hand | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hip | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Leg | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Foot | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____ | | | |

Type of Pain (mark all that apply):

- | | |
|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Dull | <input type="checkbox"/> Numbing |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Spasm | <input type="checkbox"/> Cutting |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Pounding |
| <input type="checkbox"/> Stinging | <input type="checkbox"/> Cramping |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Constricting |

Pain Frequency:

- Up to ¼ of awake time
 Up to ¼ to ½ of awake time
 Up to ½ to ¾ of awake time
 Most all of the time

Pain Intensity (how it affects your daily activities):

- Doesn't affect
 Somewhat affects
 Seriously affects
 Prevents activities

Actions Affecting This Pain:

- | | Brings on | Aggravates | Relieves |
|-----------------|--------------------------|--------------------------|--------------------------|
| In the A.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| In the P.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bending forward | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bending back | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bending left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bending right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Twisting left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Twisting right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Coughing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sneezing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Straining | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Standing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lifting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Emergency Room:

Where did you go after onset of your symptoms?

- Home
- Work
- Hospital ER _____
- Private Doctor _____

(Please provide name of Hospital or Private Doctor if applicable)

Were x-rays done? Yes No

Body parts x-rayed? _____

Results of x-rays? _____

How did you get there?

- Drove self
- Somebody else drove me
- Ambulance
- Police

Was lab work done? Yes No

What lab work was done? _____

Results of lab work? _____

Treatment received? Cervical collar Ice Other _____

Medications prescribed: _____

Follow-up instructions: _____

After the Accident: check off your symptoms immediately after and a few days following the accident.

- | | | | | |
|---|--|--|--|-------------------------------------|
| <input type="checkbox"/> headache | <input type="checkbox"/> loss of smell | <input type="checkbox"/> tension | <input type="checkbox"/> loss of taste | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> neck pain | <input type="checkbox"/> dizziness | <input type="checkbox"/> irritability | <input type="checkbox"/> toe numbness | <input type="checkbox"/> depression |
| <input type="checkbox"/> neck stiffness | <input type="checkbox"/> nausea | <input type="checkbox"/> mid back pain | <input type="checkbox"/> constipation | <input type="checkbox"/> anxious |
| <input type="checkbox"/> fainting | <input type="checkbox"/> confusion | <input type="checkbox"/> low back pain | <input type="checkbox"/> cold hands | <input type="checkbox"/> chest pain |
| <input type="checkbox"/> ringing in ears | <input type="checkbox"/> fatigue | <input type="checkbox"/> nervousness | <input type="checkbox"/> cold feet | |
| <input type="checkbox"/> pain behind eyes | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> sleeping problems | | |
| <input type="checkbox"/> others: _____ | | | | |

Prior Similar Symptoms:

Has your history contributed to your current symptoms?

- | | |
|--|---|
| <input type="checkbox"/> I have NOT had prior symptoms similar to my current complaints. | <input type="checkbox"/> My history HAS contributed to my current symptoms. |
| <input type="checkbox"/> My current complaints DID exist before, but have not been bothering me. | <input type="checkbox"/> My history HAS NOT contributed to my current symptoms. |
| <input type="checkbox"/> My current complaints ALREADY existed and were worsened. | <input type="checkbox"/> I'm NOT SURE if my history has contributed to my current symptoms. |

(If applicable) My most recent prior similar symptoms occurred _____

Treatment History: fill in any other doctor(s) seen in regards to the accident

1. Dr. _____ Specialty _____ First visit ___/___/___

Types of treatment received: _____

X-rays done? Yes No How many treatments? _____ Did treatment benefit you? Yes No

Currently treating? Yes No Last visit ___/___/___

2. Dr. _____ Specialty _____ First visit ___/___/___

Types of treatment received: _____

X-rays done? Yes No How many treatments? _____ Did treatment benefit you? Yes No

Currently treating? Yes No Last visit ___/___/___

Activities of Daily Living Assessment

Use the following 1 to 5 scale and check the appropriate box next to the number that most closely describes your current degree of difficulty. Only check the activities you do and only ONE box per activity.

Difficulties with Self Care and Personal Hygiene	Able to do without difficulty 1	Able to do despite some pain 2	Able to do despite marked pain 3	Able to do with help despite the pain 4	Unable to do at all due to pain 5
1. Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Drying hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Brushing teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Putting on shoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Preparing meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Taking out trash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Showering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Combing hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Making bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Tying shoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Doing laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Washing hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Washing face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Putting on shirt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Putting on pants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Cleaning dishes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Going toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Activity Difficulties	1	2	3	4	5
1. Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Bending back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Twisting left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Leaning back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Bending left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Twisting right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Leaning left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Reclining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Bending right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Leaning forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Leaning right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Standing for long periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Sitting for long periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Walking for long periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Kneeling for long periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Difficulties with Functional Activities	Able to do without difficulty	Able to do despite some pain	Able to do despite marked pain	Able to do with help despite the pain	Unable to do at all due to pain
	1	2	3	4	5
1. Carrying small objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Lifting weights off the floor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Pushing things while seated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Exercising upper body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Carrying large objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Lifting weights off table	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Pushing things while standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Exercising lower body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Carrying brief case	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Pulling things while seated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Exercising arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Carrying large purse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Climbing inclines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Pulling things while standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Exercising legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social & Recreational Difficulties	1	2	3	4	5
1. Bowling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Jogging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Swimming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Ice skating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Competitive sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Dating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Golfing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Dancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Skiing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Roller skating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Hobbies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Dining out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traveling Difficulties	1	2	3	4	5
1. Driving a motor vehicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Passenger in motor vehicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Passenger on a train	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Driving for long periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Passenger on an airplane	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Passenger for long periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<u>Difficulties with Different Forms of Communication</u>	Able to do without difficulty 1	Able to do despite some pain 2	Able to do despite marked pain 3	Able to do with help despite the pain 4	Unable to do at all due to pain 5
1. Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Listening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Speaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Using a keyboard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Difficulties with Senses</u>	1	2	3	4	5
1. Seeing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Sense of Touch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Sense of Taste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Sense of Smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Difficulties with Hand Functions</u>	1	2	3	4	5
1. Grasping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Holding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Pinching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Percussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Sensory Discrimination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Difficulties with Sleep & Sexual Function</u>	1	2	3	4	5
1. Being able to have a normal, restful night's sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Being able to participate in desired sexual activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please write any other Activities of Daily Living NOT covered above.

Informed Consent for Chiropractic/Physical Therapy Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor or chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I see treatment.

TO BE COMPLETED BY PATIENT

Patient's Name _____ Signature of Patient _____

Date Signed _____ Witness or Patient's Signature _____

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient's Name _____ Signature of Patient _____

Date Signed _____ Signature of Representative _____

Relationship or Authority of Patient's Representative _____

Translated by _____ Date _____

TO BE COMPLETED BY DOCTOR OR STAFF

Name of Clinic or Office _____

Address _____

Name of Doctor's treating this patient:

1. _____ PIN# _____

2. _____ PIN# _____

3. _____ PIN# _____