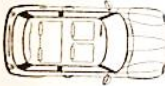


ACCIDENT / INJURY FORM

NAME: _____ DATE: _____

1. Date of your accident or when your problem began: _____

<p>A. Motor Vehicle Accident:</p> <p>Yes _____ No _____</p> <p>Driver _____ Passenger _____</p> <p>Seat Belt _____ Air Bag Deployed _____</p> <p>Indicate site of impact: "P" = Primary "S" = Secondary</p>  <p>Did you hit your head? Yes _____ No _____</p> <p>Any loss of consciousness? Yes _____ No _____</p> <p>Memory problems? Yes _____ No _____</p>	<p>B. Work Related Injury:</p> <p>Yes _____ No _____</p> <p>Has the injury been accepted as a Worker's Compensation Claim?</p> <p>Yes _____ No _____</p>
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C. Describe your accident / injury or problem in detail: _____

2. Did any of these symptoms exist prior to this accident?
Yes _____ No _____ if yes, please describe where and when: _____

3. Is there light duty available at work? Yes _____ No _____

4. Please describe your major job duties: _____

5. What treatment have you received for this injury already? _____

6. Does your present pain travel? _____ Where? _____

7. How often does it happen? _____

8. What makes it worse? _____

9. What makes it better? _____

10. Is there any stiffness? _____ Where? _____

11. Is there numbness? _____ Where? _____

12. Is there any tingling? _____ Where? _____

13. Any weakness? _____ Where? _____

14. Any swelling? _____ Where? _____

15. Grinding? _____ Where? _____

16. Locking? _____ Where? _____

17. Give away? _____ Where? _____

NAME: _____

DATE: _____

Medication Allergies: _____

Current Medications: _____

List all surgical procedures: _____

Do you have or have you had any of the following medical conditions? Circle your answer.

Hypertension: Yes No

Heart disease: Yes No

Stroke: Yes No

Diabetes: Yes No

Asthma: Yes No

Emphysema: Yes No

Peptic ulcers: Yes No

Kidney disease: Yes No

Hepatitis: Yes No

Cancer: Yes No

Thyroid disease: Yes No

Osteoporosis: Yes No

Arthritis: Yes No

List any other medical conditions you have: _____

Are there any diseases that run in your family? _____

Do you smoke? Yes No

Do you consume alcohol? Yes No

Are you currently pregnant? Yes No

How many children have you had? (Females only) _____

NAME: _____

DATE: _____

REVIEW OF SYSTEMS

Which of the following do you have?

Skin/Lymphatic

Rash or itching	Yes	No
Skin infections	Yes	No
Non-healing sores	Yes	No
Swollen glands	Yes	No
Breast lump	Yes	No
New skin spots	Yes	No

Neurologic

Fainting	Yes	No
Seizures/Convulsions	Yes	No
Dizziness	Yes	No
Memory loss	Yes	No
Severe headaches	Yes	No
Paralysis or stroke	Yes	No

Eyes

Glaucoma	Yes	No
Vision problems	Yes	No
Wear glasses/contacts	Yes	No

Ears/Nose/Throat

Hoarseness	Yes	No
Nose bleeds	Yes	No
Hearing loss	Yes	No
Ringing in the ears	Yes	No
Difficulty swallowing	Yes	No
Tooth pain or infection	Yes	No

Endocrine

Diabetes	Yes	No
Thyroid Disease	Yes	No

Hematologic

Bleed/bruise easily	Yes	No
Anemia	Yes	No
Slow healing wounds	Yes	No

Psychological

Nervousness/insomnia	Yes	No
Mental illness	Yes	No
Anxiety/depression	Yes	No

Genitourinary

Burning urination	Yes	No
Blood in urine	Yes	No
Frequent urination	Yes	No
Kidney stones	Yes	No
Male testicle pain	Yes	No
Female irregular period	Yes	No

Allergies/Immune Disorders

Anaphylactic reaction	Yes	No
Latex allergy	Yes	No
Rheumatoid disease	Yes	No
Environmental allergy	Yes	No

Gastrointestinal

Heartburn	Yes	No
Abdominal pain	Yes	No
Nausea/vomiting	Yes	No
Blood in stool	Yes	No
Loss of appetite	Yes	No
Peptic ulcer	Yes	No
Frequent diarrhea	Yes	No

Musculoskeletal

Joint pain	Yes	No
Joint swelling	Yes	No
Back pain	Yes	No
Muscle pain	Yes	No
Cold extremities	Yes	No

Constitutional

Fatigue	Yes	No
Recent weight change	Yes	No
Fever	Yes	No
Good general health lately	Yes	No

Cardiovascular

Chest pain	Yes	No
Palpitations	Yes	No
Heart trouble	Yes	No
Hypertension	Yes	No
Swelling feet, ankles, hands	Yes	No

/// for Stabbing	XXX for Burning	OOO Pins & Needles	=== Numbness	+++ Aching
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