CHIEF COMPLAINTS (WHERE DO YOU HAVE PAIN NOW)

PATIENT'S INITIAL ONLY _____ **TODAY'S DATE _____**

Where do you have pain now?

☐ Headache

☐ Facial Pain

☐ Neck Pain

☐ Upper Extremity Pain (please choose below)

☐ Shoulder ☐ Arm ☐ Elbow ☐ Forearm

☐ Wrist ☐ Hands ☐ Fingers

☐ Upper Back Pain

☐ Lower Back Pain

☐ Lower Back Extremity Pain (please choose below)

☐ Hip ☐ Thigh ☐ Knee ☐ Leg

☐ Ankle ☐ Feet ☐ Toes

☐ Other symptoms you had **AFTER** the accident

☐ Tension ☐ Nervousness ☐ Irritability ☐ Mood Swings

☐ Fatigue ☐ Depression ☐ Sleeping problems

☐ Loss of Memory ☐ Forgetfulness ☐ Loss of taste ☐ Loss of smell

☐ Dizziness ☐ Fainting ☐ Loss of Balance

☐ Upset Stomach ☐ Frequent Constipation ☐ Frequent Diarrhea

☐ Light Sensitivity with eyes ☐ Ringing/buzzing in ears

IDENTIFIER			
Your Name (initial only)		TODAY'S DATE	_____
Age:	_____		
Date of Birth	_____		
Gender			
	male	female	
Are you here by yourself?			
	yes	no	
if no, with whom are you with today?	mother	father	friend
	sister	brother	friends
	others (please specify)	_____	
Are you here with or without an interpreter?			
	with	without	
HPI			
Date of Accident	_____		
what kind of accident (automobile vs. automobile, for example, please choose two parties)?	Party 1	Party 2	
	automobile	automobile	
	motorcycle	motorcycle	
	bicycle	bicycle	
	pedestrian	pedestrian	
where are you at the time of accident?			
	sitting in the driver seat	sitting in the front passenger seat	sitting in the rear passenger seat
	ridding a bicycle	ridding a motorcycle	walking as a pedestrian
	others (please specify)	_____	
what kind of vehicle were you in (please type the make and model)?	make:	_____	
	model:	_____	
what type of vehicle?			
	sedan	SUV	pick-up truck
	bus	van	commercial truck
	bicycle	motorcycle	others (please specify)
			_____
what time did the accident take place?			
choose a time frame and AM/PM/EVENING	0 and 1	1 and 2	2 and 3
	3 and 4	4 and 5	5 and 6
	6 and 7	7 and 8	8 and 9
	9 and 10	10 and 11	11 and 12
	morning	afternoon	evening
did the accident take place on local street or freeway?			
	local street	freeway	
if on local street, on what street and city?			
	Stree Name:	_____	
	City Name:	_____	
if on freeway, which freeway?			
	Freeway Name:	_____	

which direction were you going?			
	northbound	southbound	eastbound
	westbound		
how were you hit?			
	rear-ended	broadsided from the right side	broadsided from the left side
	struck from front		
what type of vehicle struck you?			
	sedan	SUV	pick-up truck
	bus	van	commercial truck
	bicycle	motorcycle	others (please specify)
			_____
how fast were you going at the moment of impact?			
was completely stationary			
or			
was travelling at speed of	under 10 mph	10-20mph	20-30mph
	30-40mph	40-50mph	60-80mph
	80-100mph	over 100mph	not sure
how fast was the other vehicle going at the moment of impact?			
was completely stationary			
or			
was travelling at speed of	under 10 mph	10-20mph	20-30mph
	30-40mph	40-50mph	60-80mph
	80-100mph	over 100mph	not sure
did your vehicle hit another object?			
	yes	no	
if yes, please specify. If no, skip	another vehicle	center divider	light pole
	wall	fence	others
your vehicle's break was applied?			
	yes	no	Not sure
seat belt activated?			
	yes	no	
airbag deployed?			
	yes	no	
was your vehicle in a drivable condition?			
	yes	no	
was police present to the scene?			
	yes	no	
did your body have direct impact with vehicle parts?			
	yes	no	
if yes, please specify. If no, skip			
	face	forehead	chin
	head	arms	hands
	knees	feet	others
			_____
if yes, please specify. If no, skip			
	steering wheel	steering wheel column	side panel
	window	dashboard	others
			_____
did you have any visible bleeding?			
	yes	no	
if yes, please specify. If no, skip			
	face	nose	lips
	ears	Others	_____
did you have any broken tissue?			

	yes	no	
if yes, please specify. If no, skip			
	front tooth	facial bone	others
did you have loss of consciousness?			
	yes	no	
how did you feel immediately after the accident?			
	was dazed	was confused	severe pain
	was in shock		
was paramedics present at the scene?			
	yes	no	
where did you go after the accident?			
	was taken by **ambulance** to local hospital for medical attention.	was taken back home by **taxi**	drove self to medical facility to seek medical attention
	was taken by **family members** to local hospital for medical attention.	was taken back home by **family members**	others
	was taken by **friends** to local hospital for medical attention.	was taken back home by **friends**	_____
where did you feel pain the day after the accident?			
	face	head	chest
	neck	shoulder	upper back
	lower back	upper extremity	lower extremity
did you feel any of the following BESIDES pain ON the day after the accident?			
	yes	no	
if yes, please specify. If no, skip			
	dizziness	irritability	forgetfulness
			others
			_____
have you had any treatment since the accident?			
	yes	no	
if yes, please specify. If no, skip			
	chiropractic service	acunpuncture	physical therapy
	pain management	orthopedic surgery	
what kind of treatment have you had since the accident?			
	medication	nerve block	manipulation
	acupuncture	physical therapy	spine surgery
	upper extremity surgery	lower extremity surgery	Others
			_____
have you taken any medications for your pain?			
	yes	no	
if yes, please specify. If no, skip			
	Iburpofen	Tylenol	Norco
	Vicodin	Tramadol	Percocet
	gabapentin	muscle relaxant	Others
			_____
have you had any nerve blocks done for your pain?			
	yes	no	
if yes, please specify. If no, skip			
	epidural steroid injection	facet blocks	medial nerve branch blocks
	joint injections	PRP injections	Others
			_____

MEDICAL HISTORY

Past Medical History (Please check all that apply**)**

Heart attack	Stroke	Asthma	Arthritis	Seizure
Bronchitis	Ulcer	Emphysema	Diabetes	Fainting/Dizziness
Cancer	Urinary	Prostate problem	Headaches	Hepatitis
Kidney problems	High blood pressure	Gastrointestinal problem		
Others				
Any of these conditions?	Hepatitis B	Hepatitis C	HIV/AIDS	
Please answer **yes** or **no**				

Psychological History

Do you have any history of depression, anxiety, bipolar? ☐ Yes ☐ No | Please explain if **Yes** _____

Have you ever had suicidal thoughts or suicidal attempts? ☐ Yes ☐ No | Please explain if **Yes**_____

Are you currently under treatment by a psychiatrist or psychologist? ☐ Yes ☐ No | Please explain if **Yes**_____

Past Surgical History

Surgery	**Date**

Family History (Please check all that apply**)**

	Chronic Pain	Alcohol Abuse	Drug Abuse	Others Significant Medical Conditions
Father				
Mother				

Social History (Please check all that apply**)**

	Yes	No	Occasional	Regular	How Much and How Long
Smoking					
Coffee					
Alcohol					
Drugs					

	Employed	Self-employed	Unemployment	If Retired, what's your previous occupation?
Occupation (please describe)				

Marital Status	Single	Married	Divorce	Widowed
Who do you live with?				

MEDICATION

Known Allergies: Are you allergic to any of the following?

			Details	Reaction
Medications	Yes	No		
IV Contrast	Yes	No		
Food	Yes	No		
Latex	Yes	No		

Current Medication (non-pain medications)

Non-Pain Medication	Dose	How often do you take it?

Please list the CURRENT PAIN medications that you are taking

Pain Medication	Dose	How often do you take?	Is it effective? Yes / No?

ALL STUDIES: Please mark any of the following tests you have had to investigate your pain

	Description	Ordered by	Date
X-ray			
EMG/NCT			
Myelogram			
CT Scan			
MRI			

REVIEW OF SYSTEMS

Constitutional (Please check all that apply)

Fevers	Chills	Sweats	Fatigue	Appetite loss	Weight loss

Eye (Please check all that apply)

Vision loss	Light sensitivity	Double vision	Discharge	Blurred vision	Eye pain

ENMT (Please check all that apply)

Earache	Ear discharge	Ringing in the ears	Decreased hearing	Frequent colds	Difficulty swallowing
Nasal congestion	Nosebleeds	Bleeding gums	Hoarseness	Sore throat	

Cardiovascular (Please check all that apply)

Irregular heart beats	Leg cramps with exertion	Swelling of hands or feet	Fatigue	Shortness of breath with exertion	Difficulty breathing at night
Lightheadedness	Discoloration of lips or nails	Recent weight gain	Palpitation	Difficulty breathing while lying down	Chest pain or discomfort

Respiratory (Please check all that apply)

Cough	Wheezing	Chest discomfort	Shortness of breath	Excessive snoring	Coughing up blood
Excessive sputum	Sleep disturbances due to breathing				

Gastrointestinal (Please check all that apply)

Vomiting	Indigestion	Heartburn	Nausea	Change in appetite	Constipation
Excessive gas	Abdominal pain	Abdominal bloating	Hemorrhoids	Diarrhea	Bloody stools
Black or tarry stools	Change in bowel habits				

Musculoskeletal (Please check all that apply)

Joint pain	Back or neck pain	Muscle cramps	Muscle weakness	Muscle aches	Joint stiffness or swelling
Loss of strength					

Skin (Please check all that apply)

Suspicious lesions	Night sweats	Dryness	Itching	Rash	Changes in color of skin
Flushing	Poor wound healing	Excessive perspiration	Change in hair or nail		

Neurologic (Please check all that apply)

Headaches	Poor balance	Seizures	Excessive daytime sleeping	Difficulty with concentration	Sensation of room spinning
Tremors	Weakness or blackouts	Faints or blackouts	Visual disturbances	Difficulty with speaking	Disturbances in coordination
Tingling	Memory loss				

Psychiatric (Please check all that apply)

Anxiety	Nervousness	Depression	Memory change	Thoughts of suicide or violence	Frightening versions or sounds

Endocrine (Please check all that apply)

Weight change	Heat or cold intolerance	Excessive thirst or hunger	Excessive sweating or urination		

Hematologic-lymphatic (Please check all that apply)

Bleeding	Fevers	Skin discoloration	Abnormal bruising	Enlarged lymph nodes	

Allergic-immunologic (Please check all that apply)

Seasonal allergies	Hives or rash	HIV exposure	Persistent infections		

Genitourinary (Please check all that apply)

Frequent urination	Blood in urine	Burning or pain on urinary	Urinary urgency	Foul urinary discharge	Trouble starting urinary stream
Inability to empty bladder	Flank pain	Testicular pain or masses	Genital rashes or sores	Inability to control bladder	Missed periods
Unusual urinary color	Pelvic pain	Excessively heavy periods			

Patient Signature: _____ **Date: _____**