CHIEF COMPLAINTS (WHERE DO YOU HAVE PAIN NOW)

PATIENT'S INITIAL ONLY _____TODAY'S DATE

Where do you have pain now?

- ❑ Headache 头痛
- ❑ Facial Pain 面部疼痛
- ❑ Neck Pain 颈部疼痛
- ❑ Upper Extremity Pain (please choose below) 上肢疼痛（请在下面选择）
  - ❑ Shoulder 肩膀 ❑ Arm 胳膊 ❑ Elbow 手肘 ❑ Forearm 前臂
  - ❑ Wrist 手腕 ❑ Hands 手 ❑ Fingers 手指
- ❑ Upper Back Pain 上背部疼痛
- ❑ Lower Back Pain 腰痛
- ❑ Lower Back Extremity Pain (please choose below) 下肢疼痛（请在下面选择）
  - ❑ Hip 髋关节 ❑ Thigh 大腿 ❑ Knee 膝盖 ❑ Leg 腿
  - ❑ Ankle 脚踝 ❑ Feet 脚 ❑ Toes 脚趾
- ❑ Other symptoms you had **AFTER** the accident 事故发生后的其他症状

  - ❑ Tension 緊繃
  - ❑ Nervousness 紧张
  - ❑ Irritability 易怒
  - ❑ Mood Swings 情绪波动
  - ❑ Fatigue 疲劳
  - ❑ Depression 沮丧
  - ❑ Sleeping problems 睡眠问题
  - ❑ Loss of Memory 记忆力减退
  - ❑ Forgetfulness 健忘
  - ❑ Loss of taste 味觉下降
  - ❑ Loss of smell 气味消失
  - ❑ Dizziness 头晕
  - ❑ Fainting 晕倒
  - ❑ Loss of Balance 失去平衡
  - ❑ Upset Stomach 胃不舒服
  - ❑ Frequent Constipation 便秘
  - ❑ Frequent Diarrhea 经常腹泻
  - ❑ Light Sensitivity with eyes 眼睛的感光度
  - ❑ Ringing/buzzing in ears 耳鸣/嗡嗡声

IDENTIFIER			
Your Name (initial only) 您的姓名（仅缩写）		TODAY'S DATE 今天的日期	
Age 年龄:			
Date of Birth 出生日期			
Gender			
性别	Male 男性	Female 女性	
Are you here by yourself?			
你一个人来吗?	Yes 是	No 不是	
if no, with whom are you with today?	Mother 母亲	Father 父亲	Friend 朋友
如果没有，您今天和谁在一起？	Sister 姊妹	Brother 兄弟	Friends 朋友们
	others (please specify) 其他 (请列出）		
Are you here with or without an interpreter?			
您在这里带或不带翻译？	With 带	Without 不带	
HPI			
Date of Accident			
事故发生日期			
what kind of accident (automobile vs. automobile, for example, please choose two	Party 1	Party 2	
发生哪种类型的事故（例如，汽车还是汽车，请选择两个）	Automobile 汽车	Automobile 汽车	
	Motorcycle 摩托车	Motorcycle 摩托车	
	Bicycle 自行车	Bicycle 自行车	
	Pedestrian 行人	Pedestrian 行人	
where are you at the time of accident?			
出事时你在哪里？	sitting in the driver seat 坐在驾驶员座位上	sitting in the front passenger seat 坐在前排乘客座位上	sitting in the rear passenger seat 坐在后排乘客座椅上
	ridding a bicycle 骑自行车	ridding a motorcycle 骑摩托车	walking as a pedestrian 行人走路
	others (please specify)其他 (请列出）		
what kind of vehicle were you in (please type the make and model)?	Make 厂牌：		
您乘坐的是哪种车辆（请输入品牌和型号）？	Model 型号：		
what type of vehicle?			
什么类型的车辆？	Sedan 轿车	SUV 休旅车	pick-up truck 皮卡车
	Bus 共汽车	Van 货车	commercial truck 商用卡车
	Bicycle 自行车	Motorcycle 摩托车	others (please specify)
			其他 (请列出)
what time did the accident take place?			
choose a time frame and AM/PM/EVENING	0 and 1	1 and 2	2 and 3
事故什么时候发生？	3 and 4	4 and 5	5 and 6
选择时间范围和上午/下午/晚上	6 and 7	7 and 8	8 and 9
	9 and 10	10 and 11	11 and 12
	Morning 上午	Afternoon 下午	Evening 晚上
did the accident take place on local street or freeway?			
事故是否发生在当地的街道或高速公路上？	local street 当地的街道	Freeway 高速公路	
if on local street, on what street and city?			
如果在当地的街道上，在哪个街道和城市上？	Street Name 街道名称：		
	City Name 城市名称：		
if on freeway, which freeway?			
如果在高速公路上，哪个高速公路上？	Freeway Name 高速公路名称：		

which direction were you going?			
你要去哪个方向？	Northbound 北行	Southbound 南行	Eastbound 东行
	Westbound 西行		
how were you hit?			
你怎么撞上	rear-ended	broadsided from the right side	broadsided from the left side
	struck from front 正面撞击		
what type of vehicle struck you?			
什么类型的车撞到你了？	Sedan 轿车	SUV 休旅车	pick-up truck 皮卡车
	Bus 公共汽车	Van 货车	commercial truck 商用卡车
	Bicycle 自行车	Motorcycle 摩托车	others (please specify)
			其他 (请列出)
how fast were you going at the moment of impact?			
您在受到影响的那一刻速度多快？			
was completely stationary			
完全静止 or			
was travelling at speed of	under 10 mph 10 英里以下	10-20mph 10-20 英里	20-30mph 20-30 英里
行驶速度为	30-40mph 30-40 英里	40-50mph 40-50 英里	60-80mph 60-80 英里
	80-100mph 80-100 英里	over 100mph 超过 100 英里	not sure 不确定
how fast was the other vehicle going at the moment of impact?			
撞击时另一辆车行驶了多快？			
was completely stationary			
完全静止 or			
was travelling at speed of	under 10 mph 10 英里以下	10-20mph 10-20 英里	20-30mph 20-30 英里
行驶速度为	30-40mph 30-40 英里	40-50mph 40-50 英里	60-80mph 60-80 英里
	80-100mph 80-100 英里	over 100mph 超过 100 英里	not sure 不确定
did your vehicle hit another object?			
您的车辆撞到了另一个物体吗？	Yes 是	No 不是	
if yes, please specify. If no, skip	Another vehicle 另一辆车	Center divider 中央分隔线	Light pole 灯杆
如果是，请指定。 如果否，请跳过	Wall 墙	Fence 围栏	Others 其他
your vehicle's break was applied?			
您的车辆的刹车起作用吗？	Yes 是	No 不是	Not sure 不确定
seat belt activated?			
安全带启动？	Yes 是	No 不是	
airbag deployed?			
安全气囊展开？	Yes 是	No 不是	
was your vehicle in a drivable condition?			
您的车辆是否处于可行驶状态？	Yes 是	No 不是	
was police present to the scene?			
警察在现场吗？	Yes 是	No 不是	
did your body have direct impact with vehicle parts?			
您的身体对车辆零件有直接影响吗？	Yes 是	No 不是	
if yes, please specify. If no, skip			
如果是，请指定。 如果否，请跳过	Face 脸	Forehead 前额	Chin 下巴
	Head 头	Arms 胳膊	Hands 手
	Knees 膝盖	Feet 脚	Others 其他
if yes, please specify. If no, skip			
如果是，请指定。 如果否，请跳过	Steering wheel 方向盘	Steering wheel column 方向盘柱	Side panel 侧板
	Window 窗户	Dashboard 仪表板	Others 其他
did you have any visible bleeding?			
你有明显的出血吗？	Yes 是	No 不是	
if yes, please specify. If no, skip			
如果是，请指定。 如果否，请跳过	Face 脸	Nose 鼻子	Lips 嘴唇
	Ears 耳朵	Others 其他	
did you have any broken tissue?			

你有破碎的组织吗？	Yes 是	No 不是	
if yes, please specify. If no, skip			
如果是，请指定。 如果否，请跳过	front tooth 前牙	facial bone 面部骨骼	others 其他
did you have loss of consciousness?			
你失去知觉了吗？	Yes 是	No 不是	
how did you feel immediately after the accident?			
事故发生后您感觉如何？	was dazed 晕了	was confused 感到困惑	severe pain 严重的疼痛
	was in shock 感到惊吓		
was paramedics present at the scene?			
现场有护理人员吗？	Yes 是	No 不是	
where did you go after the accident?			
事故发生后你去了哪里？	was taken by **ambulance** to local hospital for medical attention. 被救护车送往当地医院救治。	was taken back home by **taxi** 被出租车带回家	drove self to medical facility to seek medical attention 自行前往医疗机构求医
	was taken by **family members** to local hospital for medical 被家人带到当地医院就医	was taken back home by **family members** 被家人带回家	Others 其他
	was taken by **friends** to local hospital for medical attention. 被朋友带到当地医院就医。	was taken back home by **friends** 被朋友带回家	
where did you feel pain the day after the accident?			
事故发生后的第二天，您在哪里感到疼痛？	Face 脸	Head 头	Chest 胸
	Neck 颈部	Shoulder 肩膀	upper back 背部
	lower back 腰	upper extremity 上肢	lower extremity 下肢
did you feel any of the following BESIDES pain ON the day after the accident?			
事故发生后的第二天，您是否感到以下任何一种疼痛？	Yes 是	No 不是	
if yes, please specify. If no, skip			
如果是，请指定。 如果否，请跳过	Dizziness 头晕	Irritability 易怒	Forgetfulness 健忘
			Others 其他
have you had any treatment since the accident?			
事故发生后您有接受过任何治疗吗？	Yes 是	No 不是	
if yes, please specify. If no, skip			
如果是，请指定。 如果否，请跳过	chiropractic service 脊骨治疗师	Acupuncture 针灸	physical therapy 物理疗法
	pain management 疼痛管理	orthopedic surgery 骨科手术	
what kind of treatment have you had since the accident?			
事故发生后您做了什么样的治疗？	Medication 药物	nerve block 神经阻滞	manipulation
	Acupuncture 针灸	physical therapy 物理疗法	spine surgery
	upper extremity surgery 上肢手术	lower extremity surgery	Others 其他
		下肢手术	
have you taken any medications for your pain?			
您是否已服用任何止痛药？	Yes 是	No 不是	
if yes, please specify. If no, skip			
如果是，请指定。 如果否，请跳过	Iburpofen 布洛芬	Tylenol 泰诺	Norco 诺可
	Vicodin 维科丁	Tramadol 曲马多	Percocet 羟考酮
	Gabapentin 加巴喷丁	muscle relaxant 肌肉鬆弛	Others 其他
have you had any nerve blocks done for your pain?			
您有没有因疼痛而做过神经阻滞？	Yes 是	No 不是	
if yes, please specify. If no, skip			
如果是，请指定。 如果否，请跳过	epidural steroid injection	facet blocks	medial nerve branch blocks 内側支神經阻滞
	joint injections 关节注射	PRP injections 富血小板血漿注射	Others 其他

MEDICAL HISTORY 医疗纪录

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

既往病史（请选中所有适用项）

Heart attack心脏病发作	Stroke中风	Asthma哮喘	Arthritis关节炎	Seizure癫痫发作
Bronchitis支气管炎	Ulcer溃疡	Emphysema气肿	Diabetes糖尿病	Fainting/Dizziness晕眩/头晕
Cancer癌症	Urinary泌尿	Prostate problem前列腺问题	Headaches头疼	Hepatitis肝炎
Kidney problems肾脏问题	High blood pressure高血压	Gastrointestinal problem肠胃问题		
Others其他				

Any of these conditions? 这些条件中的任何一个？	Hepatitis B 乙型肝炎	Hepatitis C 丙型肝炎	HIV/AIDS HIV爱滋病
Please answer **yes** or **no** 请回答是或否			

Are you currently under treatment by other health care practitioners? □ Yes □ No | Please explain if **Yes**_____

您目前正在接受其他保健医生的治疗吗？ 有 没有 |如果是，请说明

Psychological History心理病史

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

您是否有抑郁，焦虑，躁郁症的病史？ 有 没有 |如果是，请说明

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

您曾经有过自杀念头或自杀企图吗？ 有 没有 |如果是，请说明

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

您当前正在接受心理医生或心理学家的治疗吗？ 有 没有 |如果是，请说明

Past Surgical History

既往手术史

Surgery手术名	**Date日期**

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

家族病史 (请选中所有适用项)

	Chronic Pain 慢性疼痛	Alcohol Abuse 酒精滥用	Drug Abuse 滥用药物	Others Significant Medical Conditions 其他重大疾病
Father父亲				
Mother母亲				

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

社交史 (请选中所有适用项）

	Yes 是	No 否	Occasional 偶尔	Regular 定期	How Much and How Long 多少和多长时间
Smoking抽烟					
Coffee咖啡					
Alcohol喝酒					
Drugs药物					

	Employed 受雇	Self-employed 自雇	Unemployment 无业	If Retired, what's your previous occupation? 如果退休了，您以前的职业是什么？
Occupation职业 (please describe) （请描述）				

Marital Status婚姻状况	Single单身	Married已婚	Divorce离婚	Widowed丧偶
Who do you live with? 你跟谁住？				

MEDICATION ***药物***

Known Allergies: Are you allergic to any of the following?
已知的过敏：您是否对以下任何一种过敏？

			Details细节	Reaction反应
Medications 药物	Yes 是	No 否		
IV Contrast 显影剂	Yes 是	No 否		
Food 食物	Yes 是	No 否		
Latex 乳胶	Yes 是	No 否		

Current Medication (non-pain medications)
当前药物（非疼痛药物）

Non-Pain Medication **非止痛药名**	Dose 剂量	How often do you take it? 多久服用一次?

Please list the PAIN medications that you have tried for your pain in the past and their effectiveness
请列出您过去曾尝试过的止痛药及其效果

Pain Medication **止痛药名**	Dose 剂量	How often do you take? 多久服用一次?	Is it effective? Yes / No? 有效吗? 是/否？

ALL STUDIES: Please mark any of the following tests you have had to investigate your pain
所有检查：请标记您为调查疼痛而必须进行的以下任何测试

	Description描述	Ordered by	Date日期
X-ray X光			
EMG/NCT 肌電圖/神经传导			
Myelogram 脊髓造影			
CT Scan 电脑断层扫描			
MRI 磁共振成像			

REVIEW OF SYSTEMS

Constitutional (Please check all that apply)

Fevers发烧	Chills寒意	Sweats发汗	Fatigue疲劳睡觉	Appetite loss食欲不振	Weight loss体重减轻

Eye (Please check all that apply)

Vision loss视力下降	Light sensitivity感光度	Double vision双重视野	Discharge分泌物	Blurred vision模糊的视野	Eye pain眼痛

ENMT (Please check all that apply)

Earache耳痛	Ear discharge耳分泌物	Ringing in the ears耳鸣	Decreased hearing听力下降	Frequent colds经常感冒	Difficulty swallowing吞咽困难
Nasal congestion鼻塞	Nosebleeds流鼻血	Bleeding gums牙龈出血	Hoarseness嘶哑	Sore throat喉咙痛	

Cardiovascular (Please check all that apply)

Irregular heart beats 心律不齐	Leg cramps with exertion 腿抽筋	Swelling of hands or feet 手或脚肿胀	Fatigue 疲劳	Shortness of breath with exertion 劳累气短	Difficulty breathing at night 夜间呼吸困难
Lightheadedness 头昏眼花	Discoloration of lips or nails 嘴唇或指甲变色	Recent weight gain 最近体重增加	Palpitation 心悸	Difficulty breathing while lying down 躺下呼吸困难	Chest pain or discomfort 胸痛或不适

Respiratory (Please check all that apply)

Cough咳嗽	Wheezing喘息	Chest discomfort胸部不适	Excessive snoring过度打鼾	Coughing up blood咳血	
Excessive sputum 痰液过多	Sleep disturbances due to breathing 呼吸导致的睡眠障碍	Shortness of breath 呼吸急促			

Gastrointestinal (Please check all that apply)

Vomiting呕吐	Indigestion消化不良	Heartburn胃食道逆流	Nausea恶心	Constipation便秘	Bloody stools血便
Excessive gas气体过多	Abdominal pain腹痛	Abdominal bloating腹胀	Hemorrhoids痔疮	Diarrhea腹泻	
Black or tarry stools 黑便	Change in bowel habits 排便习惯改变	Change in appetite 食欲变化			

Musculoskeletal (Please check all that apply)

Joint pain 关节痛	Back or neck pain 背部或颈部疼痛	Muscle cramps 肌肉痉挛	Muscle weakness 肌肉无力	Muscle aches 肌肉疼痛	Joint stiffness or swelling 关节僵硬或肿胀
Loss of strength力量下降					

Skin (Please check all that apply)

Suspicious lesions 異常	Night sweats盗汗	Dryness干燥	Itching瘙痒	Rash皮疹	
Flushing 发红	Poor wound healing 伤口愈合不良	Excessive perspiration出汗过多	Change in hair or nail 头发或指甲改变	Changes in color of skin 皮肤颜色变化	

Neurologic (Please check all that apply)

Headaches 头疼	Poor balance 平衡不良	Seizures 癫痫发作	Excessive daytime sleeping 白天过度嗜睡	Difficulty with concentration 集中注意力困难	Sensation of room spinning 空间旋转的感觉
Tremors 发抖	Weakness or blackouts 虚弱或昏厥	Faints or blackouts 晕倒或昏厥	Visual disturbances 视觉障碍	Difficulty with speaking 说话困难	Disturbances in coordination
Tingling刺痛	Memory loss记忆丧失				

Psychiatric (Please check all that apply)

Anxiety 焦虑	Nervousness 紧张	Depression 沮丧	Memory change 记忆变化	Thoughts of suicide or violence 自杀或暴力的念头	Frightening versions or sounds 令人恐惧的影像或声音

Endocrine (Please check all that apply)

Weight change 体重变化	Heat or cold intolerance 不耐热或冷	Excessive thirst or hunger 过分的口渴或饥饿	Excessive sweating or urination 过分的出汗或排尿		

Hematologic-lymphatic (Please check all that apply)

Bleeding流血	Fevers发烧	Skin discoloration皮肤变色	Abnormal bruising异常瘀伤	Enlarged lymph nodes淋巴结肿大	

Allergic-immunologic (Please check all that apply)

Seasonal allergies 季节性过敏	Hives or rash 荨麻疹或皮疹	HIV exposure 爱滋病接触	Persistent infections 持续感染		

Genitourinary (Please check all that apply)

Frequent urination 尿频	Blood in urine 血尿	Burning or pain on urinary 尿灼痛或疼痛	Urinary urgency 尿急	Foul urinary discharge 尿道分泌	Trouble starting urinary stream 排尿困难
Inability to empty bladder 无法排空膀胱	Flank pain 腰腹痛	Testicular pain or masses 睾丸疼痛或肿块	Genital rashes or sores 生殖器皮疹或疮	Inability to control bladder 无法控制膀胱	Missed periods 经期混乱
Unusual urinary color 尿液颜色异常	Pelvic pain 骨盆疼痛	Excessively heavy periods 经期过量			

Patient Signature: _____ **Date: _____**