Check Symptoms That You Have Noticed

☐ Shortness of Breath
☐ Low Back (pain, Stiffnes)
☐ Mid Back (Pain, Stiffness)
☐ Swelling (Where)

☐ Feet/Hands Cold
☐ Restriction of Neck Motion
☐ Upper Back Pain and Stiffness
☐ Buzzing and/or Ringing In Ears
☐ Eyes Sensitive to Light, Loss of Focus
Head and Shoulders Feel Tired/ Heavy
☐ Pins and Needles in Arms/Legs
☐ Numbness in Fingers/Arms/Legs
☐ Difficulty Riding in Car
☐ Headache
☐ Neck Pain
☐ Neck Stiffness
☐ Insomnia

☐ Tension
☐ Irritability
☐ Loss of Taste
☐ Loss of Smell
☐ Loss of Memory
☐ Diarrhea
☐ Nausea
☐ Anxiety
☐ Fainting
☐ Chest Pain
☐ Dizziness
☐ Constipation
☐ Depression
☐ Eyestrain
☐ Nausea, Vomiting
☐ Face Flushed
☐ Palpitations
☐ Tremors
☐ Sinus Trouble
☐ Mental Dullness

☐ Extreme Nervousness
☐ Extreme Fatigue
☐ Pain behind Eyes
☐ Double Vision
☐ Digestive Disorders
☐ Equilibrium Problems
☐ Head Seems Too Heavy
☐ Difficulty in Excessive
☐ Standing Walking Riding Bending
☐ Neck (Pain, Stiffness) upon Arising
☐ Low Back (Pain, Stiffness) upon Arising
☐ Pain Radiating into Arm(s) Leg(s)
☐ Left ☐ Right ☐ Both
☐ Difficulty in Lifting Light
☐ Moderate Heavy
Pain Radiating Into ☐ Neck ☐ Shoulder ☐ Arms ☐ Hips ☐ Legs ☐ Base of Skull

Symptoms Other than Above _____

Have you Lost Any Days of Work? Dates From _____ To _____

Accidental Injury Report

If your visit to this clinic is due to an accident of any type, please review all events associated with the accident

DATE OF ACCIDENT _____ Hour _____ AM/PM. Location _____

How did the Accident occur? ☐ Auto Collision ☐ On The Job Injury ☐ Other _____

Please Describe the Circumstances: _____

Did you Report the Injury to Supervision or Personnel Office?		☐ YES	☐ NO
Did He/She (They) Recommend Care to Our Office?		☐ YES	☐ NO
If Auto Accident, Were You	☐ Driver	☐ Passenger	☐ Pedestrian
If Auto Collision, Were You Struck From	☐ Behind	☐ Right Side	☐ Left Side
	☐ Front	☐ Back	
Did Your Car Strike the Other(s) Involved?		☐ YES	☐ NO
Or The Other Car(s) Strike Yours?	☐ YES	☐ NO	☐ Undetermined
As a Result of the Accident, Were Traffic Citations Issued to You?		☐ YES	☐ NO
And/Or To The Driver of the Other Car(s)?		☐ YES	☐ NO

Name of Driver Who Hit You: _____

List the Extent of the Injuries As You Know Them: _____

Did you Require Hospitalization After the Accident? ☐ YES ☐ NO

Insurance Companies Involved

Your Insurance Company Name: _____ Claim # _____

Insurance Company of Person Responsible for Injuries _____

Do You Have An Attorney That Has Advised You In This Case? ☐ YES ☐ NO

Attorney's Name: _____ Address: _____ Phone _____

Patient's Signature _____ Date _____