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PATIENT QUESTIONNAIRE

Today's Date: Click here to enter a date.
Name: First name Last name
Date of Birth: Click here to enter your DOB **Age:** Current age **Sex:** **M** ☐ **F** ☐
Height: Height **Weight:** Weight in lbs
Right handed ☐ **Left handed** ☐
Vision: ☐ **Glasses** ☐ **Contact Lenses** ☐ **None**
Address: Street City Zipcode
Home Phone Home Phone **Cell phone** Cell phone
SSN: SSN
E-mail Address: E-mail address
In case of emergency notify: Emergency contact name **Phone No.:** Emergency contact phone
Referring physician: Referring physician's name **Family physician:** Family physician's name
Allergies: ☐ **None** Enter list of allergies
Medications: ☐ **None** Enter medications currently taking

ACCIDENT INFORMATION
Date of accident: Click here to enter a date.
Location in vehicle: ☐ **Driver** ☐ **Front seat passenger** ☐ **Back seat passenger**
Type of vehicle you were in: Enter type of vehicle involved in accident.
Location of accident: ☐ **Local street** ☐ **Freeway** ☐ **other:** Describe other location of accident
How did the accident happen? Description of accident.
Was your seatbelt on? ☐ **Yes** ☐ **No**
Upon impact did you move ☐ **Forward/Backward or** ☐ **Sideways**
Did the airbags inflate? ☐ **Yes** ☐ **No**
Did you lose consciousness? ☐ **Yes** ☐ **No**
Was a police report taken? ☐ **Yes** ☐ **No**
Extend of damage to the vehicle: ☐ **Total Loss** ☐ **Other:** Enter dollar amount of loss.

How did you feel immediately after the accident? Describe how you felt immediately after the accident.
Did you go to the ER? ☐ **Yes** ☐ **No**
Treatment received at the ER: Please list all treatments received in the Emergency Room.

MEDICAL TREATMENT TO DATE
Chiropractic therapy? ☐ **Yes** ☐ **No**
Chiropractor's name: Enter chiropractor's name or practice name.
Number of visits completed to date: Enter number of visits completed.
Did chiropractic treatment relieve your pain? ☐ **Yes** ☐ **No** ☐ **Temporarily**
Have you seen an orthopedic physician? ☐ **Yes** ☐ **No**
Orthopedic physician's name: Please enter orthopedic physician's name
Did the orthopedic physician recommend injections? ☐ **Yes** ☐ **No**
☐ **LESI** **Date done:** Click here to enter a date.
☐ **CESI** **Date done:** Click here to enter a date.

DIAGNOSTIC REFERRALS
MRIs done? ☐ Yes ☐ No
☐ Lumbar spine Date done: Click here to enter a date.
☐ Cervical spine Date done: Click here to enter a date.
☐ Other: Enter other body part **Date done:** Click here to enter a date.
EMG/NCV (Nerve conduction study) done? ☐ Yes ☐ No
☐ Upper extremities ☐ Lower extremities Date done: Click here to enter a date.

CURRENT SYMPTOMS: BACK
Back pain? ☐ Yes ☐ No
Pain level: ☐ Mild ☐ Moderate ☐ Severe
Location: ☐ Low back ☐ Mid back ☐ Upper back
Does the pain radiate to the legs? ☐ Yes ☐ No
Which side does the pain radiate to? ☐ Left ☐ Right ☐ Both
Pain association (check all that apply) ☐ Numbness ☐ Weakness ☐ Tingling
Description of pain (check all that apply) ☐ Aching ☐ Sharp ☐ Shooting
Nature of pain ☐ Constant ☐ Intermittent
Do you have urine or bowel issues? ☐ Yes ☐ No
Pain is better with (check all that apply) ☐ Rest ☐ Heat ☐ Ice ☐ Lack of movement ☐ Medications
Pain is worse when (check all that apply) ☐ Standing ☐ Walking ☐ Running
CURRENT SYMPTOMS: NECK
Neck pain? ☐ Yes ☐ No
Pain level: ☐ Mild ☐ Moderate ☐ Severe
Does the pain radiate to the shoulders? ☐ Yes ☐ No
Which side does the pain radiate to? ☐ Left ☐ Right ☐ Both

Does the pain radiate up the back of the neck/head? ☐ Yes ☐ No
Pain association (check all that apply) ☐ Numbness ☐ Weakness ☐ Tingling
Description of pain (check all that apply) ☐ Aching ☐ Sharp ☐ Shooting
Nature of pain ☐ Constant ☐ Intermittent
Do you have urine or bowel issues? ☐ Yes ☐ No
Pain is better with (check all that apply) ☐ Rest ☐ Heat ☐ Ice ☐ Lack of movement ☐ Medications
Pain is worse when (check all that apply) ☐ Sitting ☐ Driving ☐ Standing ☐ Movement

DAILY LIFE ACTIVITIES
Does the pain limit your daily activities? ☐ Yes ☐ No
Percentage your pain affects your activities by: Enter percentage
Does the pain affect your concentration at work? ☐ Yes ☐ No
Does the pain affect your driving? ☐ Yes ☐ No
Does the pain affect your sleep? ☐ Yes ☐ No **If yes, check all that apply ☐ Can't get into a comfortable position ☐ Lack of sleep**
Does the pain affect urination? ☐ Yes ☐ No
Does the pain affect bowel movement? ☐ Yes ☐ No

PAST INJURIES/ACCIDENTS
Have you been involved in a work related injury? ☐ Yes ☐ No
If yes, date of injury: Click here to enter a date.
Did you make a full recovery? ☐ Yes ☐ No
Have you been involved in a previous personal/automobile injury? ☐ Yes ☐ No
If yes, date of injury: Click here to enter a date.
Did you make a full recovery? ☐ Yes ☐ No