INITIAL EVALUATION

PATIENT INFORMATION

(1)_____ (2) Sex: M/F (3) Age:_____
Last Name *First* *M.I.*

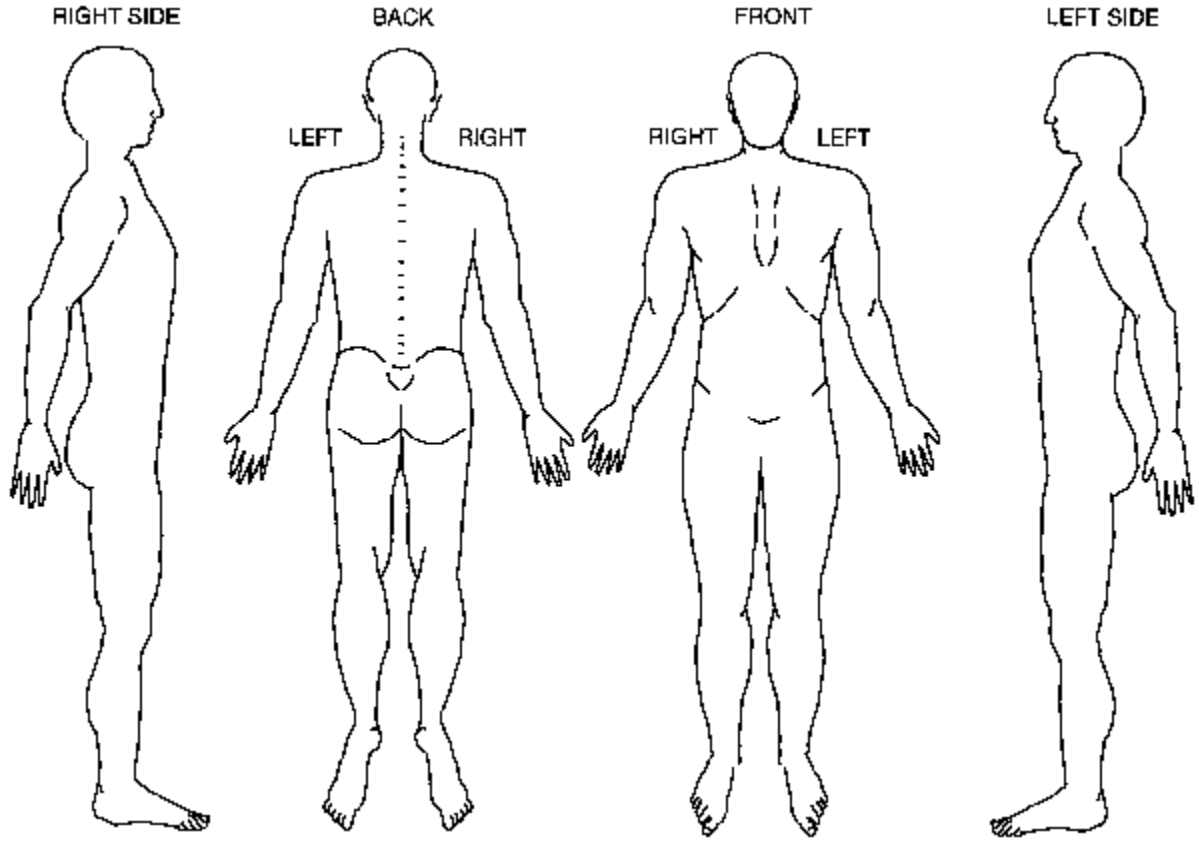
(4) Height: _____ (5) Weight: _____ Referring Physician: _____

ABOUT YOUR PAIN

(6) What is the main problem for which you are seeking treatment?

_____
_____
_____

Please mark the area(s) in which your pain is located:



Initials:_____

Please circle one: **AUTO/Slip & Fall/Worker's Comp**
Accident Details:

Where did the accident occur? Were you the (circle one): Driver / Passenger (front/back)

Were you wearing your seatbelt? YES or NO
Did you go to the hospital? YES or NO
If YES, which hospital?
Have you had any previous car accident? YES or NO
What treatment have you had?
☐Chiropractic Therapy ☐Physical Therapy ☐Medication Management ☐MRI's ☐EMG/NCV

ALLERGIES

(25) Do you have symptoms such as red itchy eyes, general itching, shortness of breath, wheezing, fast heartbeat, feeling faint, nausea, or vomiting when exposed to the following?

☐No known allergy

☐Medications: _____

Reaction:_____

☐Foods: _____

Reaction:_____

MEDICATIONS

(26) Please list your current medications with dosages:

_____
_____
_____
_____
_____

(27) Please list any previously taken pain medications that you stopped taking and the reason for stopping:

_____
_____
_____

Initials:_____

PAST MEDICAL HISTORY

(28) Have you had any of the following health problems? (Please check all that apply)

☐High Blood Pressure	☐Diabetes	☐Kidney disease
☐Angina	☐Stroke	☐Liver disease
☐Heart Attack	☐Cancer	☐Arthritis
☐Chronic cough	☐Psychological/Psychiatric problems	
☐HIV	☐Hepatitis	

Please explain any medical conditions check above:

_____

_____

_____

Other (please specify):_____

PAST SURGERIES

(29) Please list with approximate date and type of operation:

_____

_____

_____

SUBSTANCE ABUSE

(34) Are you suffering from or do you have a history of alcoholism? ☐Yes ☐No

Any illicit drug use? ☐Yes ☐No

Which of the following drugs or substances, if any, have you used in the past? (Check all that apply)

☐Alcohol ☐Barbiturates ☐Cocaine ☐Other _____

☐Heroin ☐Amphetamines ☐Marijuana (specify)

Have you ever been in a detoxification program for drug use, such as Alcoholics/Narcotics Anonymous? ☐Yes ☐No

(35) Do you or did you ever smoke cigarettes or use tobacco? ☐Yes ☐No

How many years have you smoked/did you smoke? _____

How many packs per day do you/did you smoke? _____

Have you quit using tobacco? If so, how long ago? _____

(36) How many drinks of each of the following do you consume in one week?

Beer _____ Wine _____ Liquor _____

Initials:_____