## PROBLEM or ACCIDENT/INJURY INFORMATION

### PROBLEM #2:

**Briefly explain why you are here today:**______________________________________________________

- What body part? ____________________________________________ ☐ **Right** ☐ **Left** ☐ **Bilateral**
- Have you had x-rays of this area? ☐ **Yes** ☐ **No** If yes, what facility? ____________________________________

**If yes,** do you have the X-rays with you? ☐ **Yes** ☐ **No**

Have you had an MRI of this area? ☐ **Yes** ☐ **No** If yes, what facility? ________________________________________

**If yes,** do you have the MRI with you? ☐ **Yes** ☐ **No**

**Is this an injury?** ☐ **Yes** ☐ **No**

**If yes** Injury Date: ________________ How did injury occur: __________________________________________

Where did the injury occur? ________________________________________________________________

**Type:** ☐ Motor Vehicle ☐ Sports Injury ☐ Worker's Compensation ☐ Liability ☐ Other: ______________

Is there legal action pending related to your problem? ☐ Yes ☐ No

If yes, attorney's name ________________________________________________________

Have you been treated by another healthcare provider for this problem? ☐ **Yes** ☐ **No**

**If yes**, name of provider(s)______________________________________________________________

How long were you treated? _________________________________________________________________

*Please check the boxes of the following tests/treatments you have received for this problem and tell us where you had the test/treatment.*

☐ CT Scan - Where was the test performed? _____________________________________________________

☐ Bone Scan - Where was the test performed? ______________________________________________________

☐ Nerve Conduction Test - Where was the test performed? __________________________________________

☐ Lab test(s) - Where was the test(s) performed? _________________________________________________

☐ Chiropractic

- Name of provider: ______________________________________________________________
- When did you receive treatment? _______________________________________________________

☐ Physical Therapy

- Name of provider: ______________________________________________________________
- When did you receive treatment? _______________________________________________________

**DESCRIPTION OF PAIN and SYMPTOMS:**

**Was the onset of your pain:** ☐ Sudden ☐ Gradual

**How long have you had this pain:** _________ ☐ days ☐ weeks ☐ months ☐ years

**On a scale from 0-10, rate your pain, 0-None - 10-unbearable:** __________

**Have you had this pain before?** ☐ Yes ☐ No **If yes, how long ago?** ____________________________

**How often do you have pain?** ☐ Intermittent ☐ Occasional ☐ Constant ☐ Rare

**Is your pain:** ☐ Changing ☐ Stable ☐ Worsening ☐ Improving ☐ Resolved

**Does your pain radiate:** ☐ Yes ☐ No Radiates to:_____________________________

**How does your pain feel?** ☐ Aching ☐ Burning ☐ Dull ☐ Piercing ☐ Sharp ☐ Throbbing ☐ Other_________

**What aggravates your symptoms/pain?**

| | | | |
|---|---|---|---|
| ☐ Bending | ☐ Lifting | ☐ Sitting | ☐ Other:______________________________ |
| ☐ Climbing Stairs | ☐ Movement | ☐ Standing | ☐ **Nothing** |
| ☐ Descending Stairs | ☐ Pushing | ☐ Walking | |

**What reduces your symptoms/pain?**

| | | | |
|---|---|---|---|
| ☐ Brace/Splint | ☐ Ice | ☐ Mobility | ☐ Rest |
| ☐ Elevation | ☐ Injection | ☐ Ibuprofen | ☐ Stretching |
| ☐ Exercise | ☐ Massage | ☐ Tylenol | ☐ Other:______________________ |
| ☐ Heat | ☐ Prescription Meds | ☐ Physical Therapy | ☐ **Nothing** |

**Associated Symptoms:** Please mark the symptoms you currently are experiencing:

| | | |
|---|---|---|
| ☐ Bruising | ☐ Limping | ☐ Spasms |
| ☐ Grinding | ☐ Locking | ☐ Swelling |
| ☐ Decreased mobility | ☐ Nighttime awakening | ☐ Tingling in the arms |
| ☐ Difficulty initiating sleep | ☐ Nighttime pain | ☐ Tingling in the legs |
| ☐ Joint instability | ☐ Numbness | ☐ Weakness |
| ☐ Joint tenderness | ☐ Popping | ☐ **No concerns with any of these** |

Other associated symptoms: ________________________________________________________________