Florida Functional Neurology Group
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**ALEXANDER C. FRANK,** DC, DACNB, FABES
*BOARD CERTIFIED CHIROPRACTIC NEUROLOGIST*
DIPLOMATE, AMERICAN CHIROPRACTIC NEUROLOGY BOARD
FELLOW, AMERICAN BOARD OF ELECTRODIAGNOSTIC SPEICALTIES

Welcome to my office,

Please take your time in filling out your intake documents. The documents were designed to be filled-out on your computer. You can move from field to field via the TAB key, or you can use your mouse and cursor to select a specific field. You can also print off the documents and fill them in by hand, *neatly.*

Please include with the new patient documents any recent medical reports, imaging and their reports, tests and their results, etc. A record's release form is included and should be returned as soon as possible so I can review your documents *prior* to the initial evaluation. If you have seen multiple physicians due to a significant health history, it is in your best interest to organize your treating physicians, their diagnoses, treatments, medication, etc., into a chronologically-coherent document. This is for ***your benefit***, as it will expedite your care and road to recovery.

Please wear/bring loose/athletic clothing for the examination. Bring warm clothing such as a sweat suit & socks, if you tend to get cold. The exam takes approximately 45 minutes to 1 hour. Please arrive *at least* 20 minutes prior to your scheduled initial appointment to enter the necessary information.

I look forward to being a part of your health care team.

Cordially,

Alexander C. Frank, DC, DACNB, FABES

Florida Functional Neurology Group
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1317 SE 25th Loop Ste. 102, FL. 34471
4076 E. FL-44 Ste. 14, Wildwood, FL. 34785
3409 Powerline Rd Ste 1104, Oakland Park, FL. 33309
P: 352-571-5155 info@FFNG.org F: 352-877-9637

**Confidential Patient Information**

Patients Name:_____ Chief Complaint:_____

Address:_____ Home Phone:_____

_____ Cell: _____

Email:_____ Marital Status: M S W D

Date of Birth:_____ Employer:_____

Occupation:_____ Previous Chiropractic Care: No / Yes

Referred by:_____

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___Yes___No

Surgeries:

| | | |
|---|---|---|
| ☐ Tonsillectomy | ☐ Thyroid surgery | ☐ Neurosurgery |
| ☐ Gall bladder removal | ☐ Stomach surgery | ☐ Spinal surgery |
| ☐ Appendectomy | ☐ Rectal surgery | ☐ Cardiac surgery |
| ☐ Hernia repair | ☐ Abdominal surgery | ☐ Orthopedic surgery |
| ☐ Breast implant surgery | ☐ Tubes in ears | ☐ Female surgery |
| ☐ Cesarean Section | ☐ Knee/hip replacement L / R | ☐ Male Surgery |
| | ☐ Shoulder L R | |

Other: _____ When_____

Recent Illness? _____ _____

Cancer? Y/ Diabetes? High Blood Press Thyroid Issues Psychological Tremors? Falls/Balance

**Autoimmunity:** N/ Y:_____ **Allergies** N / Y:_____

**Sensitivities?** Chemical ☐ Scent ☐ Metal ☐ WiFi ☐ Other:_____ **Memory/Recall/Word Retrieval:** Y/ N

**Bowels** Regular Irregular Constipation Diarrhea **Bladder**: Regular Incontinence Trouble starting Trouble stopping ☐

**Smoke:** Never Quit a long time ago Current Trying to Quit **Soda** Y/N **Coffee** Y/N **Card Accident(s)**: N/Y: how many?_____ **Concussion** N/Y:_____?

**Sleep: E**asily fall asleep Y/N **S**tay asleep? Y/N why? pain urinate **A**waken feeling rested? Y/N Average hours of sleep: _____ Nap during day Y/N

**P**acemaker? N/Y **Ur/Col Ostomy?** N/Y **Spinal Stimulator** N/Y Hardware: Cervical Lumbar Joint: Shoulder Hip Knee Other:_____

Previous Care for this(ese) Complaint(s): Medical Medication Physical Therapy Chiropractic Past Care: Helped Transient Relief Did not Help

Previous Imaging? N / Y; location : Lake Medical Imaging (LMI) Sharon Morse Hospital Medical Imaging & Therapeutics (MIT) Sandlake Imaging Other:_____

Neck: Xray MRI CT Year:_____ Low Back: Xray MRI CT Year:_____ Other:_____

Please included a list of all current medications and/or supplements; their dosages and brand (see back of form)

_____ _____

**Signature of Patient/Parent /Guardian** **Date**

1317 SE 25TH LOOP #102 OCALA, FL. 34471
4706 East FL-44 #14, Wildwood, FL. 34785
3409 NW 9th Ave #1104, Oakland Park, FL. 33309

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A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course will not give any treatment or care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known that he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The board certified chiropractic neurologist provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient, I am authorizing FFNG and its' staff to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

To the best of my knowledge I am pregnant_____ I am NOT pregnant_____

I give my permission to X-ray_____ I DO NOT give my permission to x-ray me for diagnostic interpretation. _____

**Missed Appointments:**

There is a possible $25 fee charged for all appointments that are not canceled prior to scheduled visit.

**Consent to Evaluate and Treat a Minor:**

_____being the parent or legal guardian of_____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

**Communications:**

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

_____ None

May we mail postcards or leave messages on any answering device, i.e. home answering machines or voicemails? Yes_____ No_____

**Acknowledgement:**

I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon reques I will be given a copy.

I, _____ , have read and fully understand the above statements.

Signature:_____ Date_____


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**Your last office visit from your medical physician SHOULD contain all your current medications. Make sure to sign the Records Requestso that we can request these documents**

| Medication Name | Dosage | Physician |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |
| Medical Physicians | Conditions | Contact Info |
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |

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**Alexander C. Frank**, D.C., D.A.C.N.B., F.A.B.E.S.
Board Certified Chiropractic Neurologist
Diplomate, American Chiropractic Neurology Board
Fellow, Electrodiagnostic Specialties

Please describe in your own words the condition(s) you are seeking evaluation for. When did it start? What makes it better? What makes it worse? Information such as "pain is worse in the morning", or "the pain reduces when I lay on my left side". What has/has not helped?

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Name: _____

Date: _____

# Concussion/Mild Traumatic Brain Injury Intake Form

Please provide us with some information about your injury, if you do not understand a question, your therapist will assist you during the evaluation.

**Date/Time of Injury**: _____ **Injury description**: _____

_____

**1b. Location of Impact:** On the head- ☐ Front ☐ Left Front ☐ Right Front ☐ Left Back ☐ Right Back ☐ Back
Other location- ☐ Neck ☐ Body

**2. Cause:** ☐ Car accident ☐ Hit by a car ☐ Fall ☐ Assault ☐ Sports (specify)_____ ☐ Other _____

**3. Are there any events just BEFORE the injury that you have no memory of (even brief)?** ◯ Yes ◯ No Duration_____

**4. Are there any events just AFTER the injury that you have no memory of (even brief)?** ◯ Yes ◯ No Duration_____

**5. Did you lose consciousness?** ◯ Yes ◯ No Duration_____

**6. Early Signs:** ☐ Dazed or stunned ☐ Confused about events ☐ Slow to respond ☐ Dizzy ☐ Forgetful ☐ Repeating things

**7. Were seizures observed?** ◯ Yes ◯ No If **yes**, please provide details_____

8. **Did you receive medical attention at the time of the injury?** ◯ Yes ◯ No If **yes**, please explain, including any tests & results:

_____

Since the injury, have you experienced any of these symptoms more than usual **today** or **in the past day**?

| | | | | |
|---|---|---|---|---|
| ☐ Headache | ☐ Fatigue | ☐ Difficulty Concentrating | ☐ Drowsiness | ☐ Sleeping more than usual |
| ☐ Nausea | ☐ Sensitivity to light | ☐ Difficulty remembering | ☐ Trouble falling asleep | ☐ Sleeping less than usual |
| ☐ Vomiting | ☐ Sensitivity to noise | ☐ Irritability | | |
| ☐ Balance Problems | ☐ Numbness/tingling | ☐ Sadness | | |
| ☐ Dizziness | ☐ Feeling mentally foggy | ☐ More emotional | | |
| ☐ Visual Problems | ☐ Feeling slowed down | ☐ Nervousness | | |

**Exertion**: Do these symptoms worsen with:
Physical Activity SELECT ONE
Concentration/thinking SELECT ONE

**Has anything like this ever happened in the past?** SELECT ONE
If yes, how many times? SELECT ONE
What's the longest you experienced symptoms? ◯ Days ◯ Weeks ◯ Months ◯ Years

| Vision | Headache (HA) | Developmental | ✓ | Psychiatric | ✓ |
|---|---|---|---|---|---|
| History of vision change or disturbance? ◯ Y ◯ N | Prior treatment for HA? ◯ Y ◯ N | Learning disabilities | | Anxiety | |
| If yes, please explain: _____ | History of migraine headache | ADD/ADHD | | Depression | |
| _____ | ☐ Personal ☐ Family | Other Developmental Disorder_____ | | Sleep Disorder | |
| | _____ | | | Other psychiatric disorder | |

**How do you learn best**? By:
☐ Hearing it ☐ Reading it ☐ Seeing it demonstrated ☐ Performing it yourself ☐ Observing someone else

**Rate** your **average pain** or symptom on a scale of 0-10 with **"0" equals to no pain** and **"10" equals the worst imaginable**.
→ Mark the line at the point that represents your pain or symptom.

0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 SELECT ONE

**Rate** how near you are to your **normal function** on a scale of 0-10 by with **"0" equals not able** to perform ***any*** of your normal activities and "**10" equals able** to do ***all*** normal activities without difficulty. → Mark the line at the point that represents your level of function.

0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 SELECT ONE

**Which skills or abilities do you hope to regain by coming to therapy?** _____

Which of the following over the counter medications are you taking or have taken in the last week?

☐ Ibuprofen (Advil) ☐ Antihistamines ☐ Decongestants ☐ Naturopathic ☐ Vitamins ☐ Antacids
☐ Aspirin ☐ Laxatives ☐ Tylenol ☐ Naproxen Sodium (Aleve) ☐ Other: _____

Which of the following prescription medications are you taking?

☐ Allergy ☐ Hormones ☐ Pain ☐ Tone/Spasticity Reduction ☐ Other:_____
☐ Antibiotic ☐ Diabetes ☐ Reflux ☐ Cholesterol_____
☐ Anti-inflammatory ☐ Depression ☐ Seizure ☐ Thyroid
☐ Blood Pressure ☐ Respiratory ☐ Anti-nausea ☐ Bladder
☐ Heart ☐ Muscle Relaxant ☐ Blood Thinners ☐ MS Med/Fatigue

Medical History: For new patients only

☐ ADD/AHD
☐ Amputation
☐ Autism
☐ Auto Immune Disease: _____
☐ Balance Problems
☐ Bowel/Bladder Problems
☐ Cancer: _____
☐ Cardiac Condition: _____
☐ Chemical Dependency
☐ Chronic Otitis Media
☐ Cleft Palate
☐ Dementia
☐ Depression
☐ Diabetes
☐ Dizziness
☐ DVT's
☐ Failure to Thrive
☐ Falls
☐ Feeding/Swallowing Problems
☐ Fibromyalgia
☐ Fractures: _____
☐ Gastrointestinal: _____
☐ Hepatitis
☐ Hearing Loss
☐ Headaches/Migraines
☐ High Blood Pressure (Hypertension)
☐ Labor/Delivery Complication
☐ Neurological Condition: _____
☐ Noise Exposure
☐ Osteoarthritis
☐ Osteoporosis
☐ Psychological Condition: _____
☐ Respiratory Condition: _____
☐ Rheumatoid Arthritis
☐ Seizures
☐ Sleep disturbances
☐ Thyroid
☐ TMJ
☐ Vision
☐ Voice
☐ Other: _____

Do you have any known allergies: Drug_____ Food _____ Other _____

Social History:

1. Support system:
   ☐ Married ☐ Single ☐ Widowed ☐ Significant other: _____
2. Living arrangement:
   ☐ Home/alone ☐ Home w/family ☐ Assisted living center ☐ Adult Foster home
   ☐ Children at home #: _____ Ages of Children_____
3. Amount of help currently needed at home:
   ☐ None ☐ Part of the day ☐ During the day ☐ During the night ☐ 24 hours a day
4. Home Accessibility:
   ☐ # of Stairs/Steps ☐ Walk-in Shower ☐ Rail ☐ Tub/shower combination
5. Assistive Devices/Equipment:
   ☐ Cane ☐ Bath bench ☐ Resting splints ☐ Walker ☐ Brace
   ☐ Raised toilet seat ☐ Commode ☐ Prosthesis ☐ Wheelchair/scooter ☐ Grab bars
   ☐ Hospital bed ☐ Dressing equipment ☐ Hearing aids ☐ Glasses ☐ Lifeline

Work History: **Student** ☐ Occupation: _____

Current Status? ☐ Full duty ☐ Temporary disability ☐ Permanent disability ☐ Applied for disability

☐ Retired ☐ Volunteer ☐ Light duty ☐ Modified duty/job restrictions are: _____

Anticipated return to work date or work status change? _____

Physician follow-up: ☐ Physician recheck is scheduled for this date: _____

SIGNATURE:_____

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**Name:** _____ **Date:** _____

# DIZZINESS QUESTIONNAIRE

I. When you are "dizzy" do you experience any of the following sensations? Please read the entire list first, then circle the number of all the statements that describe your feelings.

☐ 1. When dizzy I feel lightheaded
☐ 2. There is a swimming sensation in the head
☐ 3. I black out or faint.
☐ 4. I have been unconscious for more than a few seconds.
☐ 5. I tend to fall to the right.
☐ 6. I tend to fall to the left
☐ 7. I tend to fall forward.
☐ 8. I tend to fall backward
☐ 9. The room or objects spin or turn around me.
☐ 10. I feel a sensation that I am turning or spinning inside, with outside objects remaining stationary.
☐ 11. I lose my balance when walking - Veering to the right.
☐ 12. I lose my balance when walking - Veering to the left.
☐ 13. I have a headache.
☐ 14. I feel nauseated.
☐ 15. I have vomited
☐ 16. I have pressure in the head
☐ 17. I have fallen or injured myself from being dizzy.
☐ 18. My dizziness is constant, all the time.
☐ 19. My dizziness comes in attacks but I am completely free of dizziness between attacks
☐ 20. My dizziness is worse in attacks, and I am somewhat dizzy between attacks
☐ 21. My dizziness occurs only in certian positions
☐ 22. My dizziness occurs only with movement
☐ 23. When I am dizzy, I must support myself when standing
☐ 24. My dizziness is worse with couging or straining

25. What will stop your dizziness or makes it better? _____

26. What will make your dizziness worse? _____

27. If you have attacks: How many attacks per day: ___ per week ___ per month ___
How long do they usually last? seconds ___ minutes ___ hours ___
Do you have any warning that the attack is about to start? Yes ☐ No ☐
What will begin an attack? _____

II. If you have any of the following symptoms, put an "X" in the appropriate box.

| Both Ears | Right Ear | Left Ear | No | | |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | 1. | Difficulty in hearing: When did it start: _____, ☐ suddenly, ☐ gradually<br>Is it getting worse ◯, getting better ◯, the same ◯ |
| ☐ | ☐ | ☐ | ☐ | 2. | Noise in your ears. Describe the noise _____<br>When dizzy, is the noise louder ☐, softer ☐, higher pitch ☐, lower pitch ☐<br>If anything stops the noise or makes it better, what _____ |
| ☐ | ☐ | ☐ | ☐ | 3. | Fullness or stuffiness in your ears. When you are dizzy, is it better ☐, worse ☐, same ☐ |
| ☐ | ☐ | ☐ | ☐ | 4. | Pain in your ears. |
| ☐ | ☐ | ☐ | ☐ | 5. | Discharge from your ears. |
| ☐ | ☐ | ☐ | ☐ | 6. | Have you ever had ear surgery? |

III. If you have ever experienced any of the following symptoms, please select the appropriate box

| | No | Constantly | In attacks when not dizzy | In attacks when dizzy |
|---|---|---|---|---|
| 1. Double Vision. | ☐ | ☐ | ☐ | ☐ |
| 2. Numbness of face, arms, or legs. | ☐ | ☐ | ☐ | ☐ |
| 3. Blurred vision or blindness. | ☐ | ☐ | ☐ | ☐ |
| 4. Weakness in arms or legs. | ☐ | ☐ | ☐ | ☐ |
| 5. Clumsiness in arms or legs. | ☐ | ☐ | ☐ | ☐ |
| 6. Confusion or loss of consciousness. | ☐ | ☐ | ☐ | ☐ |
| 7. Difficulty with speech. | ☐ | ☐ | ☐ | ☐ |
| 8. Difficulty with sallowing. | ☐ | ☐ | ☐ | ☐ |
| 9. Tingling around the mouth | ☐ | ☐ | ☐ | ☐ |
| 10. Spots before the eyes. | ☐ | ☐ | ☐ | ☐ |
| 11. Do you get dizzy after exertion or overwork? | | | Yes ◯ | No ◯ |
| 12. Did you get new glasses recently? | | | Yes ◯ | No ◯ |
| 13. Do you tend to get upset easily? | | | Yes ◯ | No ◯ |
| 14. Do you get dizzy when you have not eaten for a long time? | | | Yes ◯ | No ◯ |
| 15. Is your dizziness connected with your menstrual period? | | | Yes ◯ | No ◯ |
| 16. Have you ever had a neck injury or whiplash? | | | Yes ◯ | No ◯ |
| 17. Were you exposed to any irritating fumes, paints, etc., at onset of dizziness? | | | Yes ◯ | No ◯ |
| 18. Did you ever injure your head? | | | Yes ◯ | No ◯ |
| If you were unconsious how long? seconds _____ minutes_____ hours_____ days_____ weeks_____ | | | | No ☐ |
| 19. Do you use alcohol? | | | Yes ◯ | No ◯ |

You can type in the area below to provide more information about your history of vertigo/dizziness

# HEADACHE DISABILITY INDEX

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NAME: _____ DATE: _____ AGE: ____ SCORES TOTAL: ____; E____; F____
(100) (52) (48)

**INSTRUCTIONS: Please CIRCLE the correct response:**

1. I have headache: ◯ 1 per month ◯ more than but less than 4 per month ◯ more than one per week.
2. My headache is: ◯ mild ◯ moderate ◯ severe

**INSTRUCTIONS: *PLEASE READ CAREFULLY:*** The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each item as it pertains to your headache only.

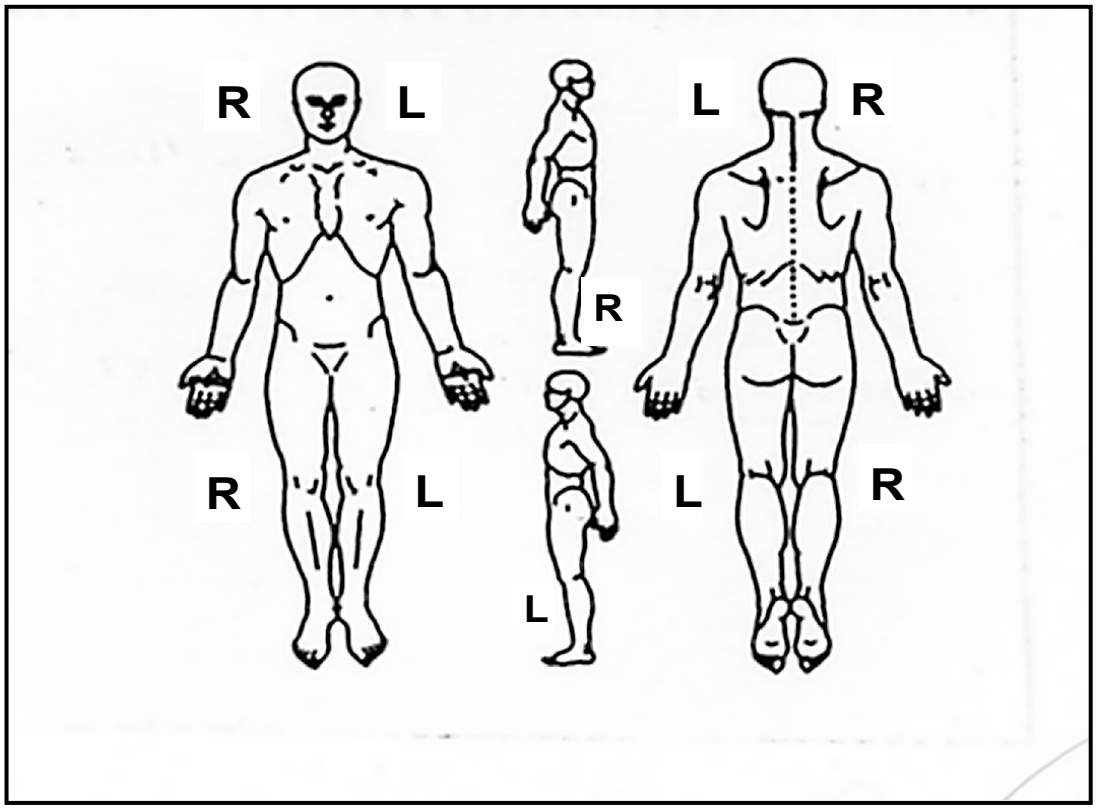
| | YES | SOMETIMES | NO |
|---|---|---|---|
| **E1. Because of my headaches I feel handicapped.** | ◯ | ◯ | ◯ |
| **F2. Because of my headaches I feel restricted in performing my routine daily activities.** | ◯ | ◯ | ◯ |
| **E3. No one understands the effect my headaches have on my life.** | ◯ | ◯ | ◯ |
| **F4. I restrict my recreational activities (e.g. sports, hobbies) because of my headaches** | ◯ | ◯ | ◯ |
| **E5. My headaches make me angry.** | ◯ | ◯ | ◯ |
| **E6. Sometimes I feel that I am going to lose control because of my headaches** | ◯ | ◯ | ◯ |
| **F7. Because of my headaches I am less likely to socialize.** | ◯ | ◯ | ◯ |
| **E8. My spouse/significant other, or family and friends have no idea what I am going through because of my headaches.** | ◯ | ◯ | ◯ |
| **E9. My headaches are so bad that I feel I am going to go insane.** | ◯ | ◯ | ◯ |
| **E10. My outlook on the world is affected by my headaches.** | ◯ | ◯ | ◯ |
| **E11. I am afraid to go outside when I feel a headache is starting.** | ◯ | ◯ | ◯ |
| **E12. I feel desperate because of my headaches.** | ◯ | ◯ | ◯ |
| **F13. I am concerned that I am paying penalties at work or at home because of my headaches.** | ◯ | ◯ | ◯ |
| **E14. My headaches place stress on my relationships with family or friends.** | ◯ | ◯ | ◯ |
| **F15. I avoid being around people when I have a headache.** | ◯ | ◯ | ◯ |
| **F16. I believe my headaches are making it difficult for me to achieve my goals in life.** | ◯ | ◯ | ◯ |
| **F17. I am unable to think clearly because of my headaches.** | ◯ | ◯ | ◯ |
| **F18. I get tense (e.g. muscle tension) because of my headaches.** | ◯ | ◯ | ◯ |
| **F19. I do not enjoy social gatherings because of my headaches.** | ◯ | ◯ | ◯ |
| **E20. I feel irritable because of my headaches.** | ◯ | ◯ | ◯ |
| **F21. I avoid traveling because of my headaches.** | ◯ | ◯ | ◯ |
| **E22. My headaches make me feel confused.** | ◯ | ◯ | ◯ |
| **E23. My headaches make me feel frustrated.** | ◯ | ◯ | ◯ |
| **F24. I find it difficult to read because of my headaches.** | ◯ | ◯ | ◯ |
| **F25. I find it difficult to focus my attention away from my headaches and on other things.** | ◯ | ◯ | ◯ |

Reference: Jacobson Gary P., Ramadan NM, et al., The Henry Ford Hospital Headache Disability Inventory (HDI). Neurology 1994; 44:837-842
FORM 502

Name: _____

**SYMPTOM CHART:** *[If you are currently experiencing symptoms, on the chart below place an **X** on **all** the area(s) where symptom(s) are present.]*

10/11




## Rate your pain levels on a scale of 0-10

**0** = There are times, when I am awake, that I do not notice pain.
**9** = I almost pass out because of pain and I cannot get out of bed.
**10** = I pass out because of pain.

## ***Neck Pain:***

My Neck pain is

This pain when at its ***worst*** = 0
This pain when at its ***best*** = 0

Timing -Select One

Check all that apply for the quality of your **neck** symptoms:

☐ Stiff ☐ Pressure ☐ Dull ☐ Numbness ☐ Pulling ☐ Sharp
☐ Pins/Needles ☐ Burning ☐ Tingling ☐ Ache ☐ Other_____ __ Other_____

Where does the pain radiate to? _____

How long after the accident did you begin to feel **neck** related symptoms? _____

## ***Upper / Mid Back:***

My Mid Back pain is

This pain when at its ***worst*** = 0
This pain when at its ***best*** = 0

Timing -Select One

***Check all that apply*** ☐ Upper Back ☐ Goes into my neck ☐ Mid Back ☐ Shoulder Blades
☐ Goes in to lower back ☐ Other _____ ____ Other _____

Check all that apply for the quality of your **upper / mid back** symptoms:

☐ Stiff ☐ Pressure ☐ Dull ☐ Numbness ☐ Pulling ☐ Sharp
☐ Pins/Needles ☐ Burning ☐ Tingling ☐ Ache ☐ Other_____ __ Other_____

Where does the pain radiate to? _____

How long after the accident did you begin to feel **upper / mid back** related symptoms? _____



*Cont.*

Name: _____

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## Rate your pain levels on a scale of 0-10

**0** = There are times when I am awake that I do not notice pain.
**9** = I almost pass out because of pain and I cannot get out of bed.
**10** = I pass out because of pain.

11/11

## *Low Back Pain:*

My **Low back** pain is

This pain when at its ***worst*** select one
This pain when at its ***best*** = select one

Timing -Select One

Check all that apply for the quality of your **low back** symptoms:

☐ Stiff ☐ Pressure ☐ Dull ☐ Numbness ☐ Pulling ☐ Sharp
☐ Pins/Needles ☐ Burning ☐ Tingling ☐ Ache ☐ Other_____ __ Other_____

Where does your pain radiate to? _____

How long after the accident did you begin to feel **low back** related symptoms? _____

## *Headaches:*

My **headaches** are

My **headaches** when at its ***worst***= select one
My **headaches** when at its ***best*** = select one

Timing -Select One

How many days a week do you have **headaches**? select one 7 How many headaches do you have a day? 0

Check all that apply for the quality of your **headache** symptoms:

☐ Throbbing ☐ Pulsating ☐ Pounding ☐ Constant ☐ Tight
☐ Squeezing ☐ Pressure ☐ Sharp ☐ Grinding ☐ Tender

Please mark symptoms that are associated with your **headaches:**

☐ Loss of consciousness ☐ Light sensitivity ☐ Nausea or vomiting ☐ Noise sensitivity ☐ Dizziness
☐ Neck stiffness ☐ Numbness in face/arm/hand ☐ Visual disturbances ☐ Other _____

How long after the accident did you begin to feel your **headaches**? _____

## *Extremity:*

Left / Right **(circle one)**

**(circle one)** Arm / Shoulder / Elbow / Wrist / Hand / Fingers / Leg / Hip SIDE select one Other _____

This pain when at its ***worst***= select one
This pain when at its ***best*** = select one

This pain is

Timing -Select One

Check all that apply for the quality of these symptoms:

☐ Stiff ☐ Pressure ☐ Dull ☐ Numbness ☐ Pulling ☐ Sharp
☐ Pins/Needles ☐ Burning ☐ Tingling ☐ Ache ☐ Pinching ☐ Throbbing
☐ Nagging ☐ Other_____

How long after the accident did you begin to feel **these** symptoms? _____

## *Extremity:*

Left / Right **(circle one)**

**(circle one)** Arm / Shoulder / Elbow / Wrist / Hand / Fingers / Leg / Hip/Thig SIDE select one Other _____

This pain when at its ***worst***= select one
This pain when at its ***best*** = select one

This pain is

Timing -Select One

Check all that apply for the quality of these symptoms:

☐ Stiff ☐ Pressure ☐ Dull ☐ Numbness ☐ Pulling ☐ Sharp
☐ Pins/Needles ☐ Burning ☐ Tingling ☐ Ache ☐ Pinching ☐ Throbbing
☐ Nagging ☐ Other_____

How long have you felt these symptoms? _____

Please provide any additional symptoms / information here: _____

_____

_____

_____

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Patient:_____

DOB:

## Review of Systems

Please check all that apply

**General-**
□ Weight loss or gain
□ Fatigue
□ Fever or chills
□ Weakness
□ Trouble sleeping

**Skin-**
□ Rashes
□ Lumps
□ Itching
□ Dryness
□ Color changes
□ Hair and nail changes

**Head-**
□ Headache
□ Head injury
□ Neck Pain

**Ears-**
□ Decreased hearing
□ Ringing in ears
□ Earache
□ Drainage

**Eyes-**
□ Vision Loss/Changes
□ Glasses or contacts
□ Pain
□ Redness
□ Blurry or double vision
□ Flashing lights
□ Specks
□ Glaucoma
□ Cataracts
□ Last eye exam

**Nose-**
□ Stuffiness
□ Discharge
□ Itching
□ Hay fever
□ Nosebleeds
□ Sinus pain

**Throat-**
□ Bleeding
□ Dentures
□ Sore tongue
□ Dry mouth
□ Sore throat
□ Hoarseness
□ Thrush
□ Non-healing sores

**Neck-**
□ Lumps
□ Swollen glands
□ Pain
□ Stiffness

**Breasts-**
□ Lumps
□ Pain
□ Discharge
□ Self-exams
□ Breast-feeding

**Respiratory-**
□ Cough
□ Sputum
□ Coughing up blood
□ Shortness of breath
□ Wheezing
□ Painful breathing

**Cardiovascular-**
□ Chest pain or discomfort
□ Tightness
□ Palpitations
□ Shortness of breath with activity
□ Difficulty breathing lying down
□ Swelling
□ Sudden awakening from sleep with shortness of breath

**Gastrointestinal-**
□ Swallowing difficulties
□ Heartburn
□ Change in appetite
□ Nausea
□ Change in bowel habits
□ Rectal bleeding
□ Constipation
□ Diarrhea
□Yellow eyes or skin

**Urinary-**
□ Frequency
□ Urgency
□ Burning or pain
□ Blood in urine
□ Incontinence
□ Change in urinary strength

**Vascular-**
□ Calf pain with walking
□ Leg cramping

**Musculoskeletal-**
□ Muscle or joint pain
□ Stiffness
□ Back pain
□ Redness of joints
□ Swelling of joints
□ Trauma

**Neurologic-**
□ Dizziness
□ Fainting
□ Seizures
□ Weakness
□ Numbness
□ Tingling
□ Tremor

**Hematologic-**
□ Ease of bruising
□ Ease of bleeding

**Endocrine-**
□ Head or cold intolerance
□ Sweating
□ Frequent urination
□ Thirst
□ Change in appetite

**Psychiatric-**
□ Nervousness
□ Stress
□ Depression
□ Memory loss

Signature _____

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# AUTHORIZATION TO RELEASE & RECEIVE X-RAYS & INFORMATION

TO:_____
(NAME OF HEALTH CARE PROVIDER, CLINIC, HOSPITAL, ETC.)

Contact info:_____

I, _____ DOB:_____
(PATIENT'S NAME)

☐ Imaging ☐ Reports ☐ Test Results

☐


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**NOTICE OF PRIVACY PRACTICES**

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PATIENT NAME: _____ DATE: _____

PATIENT SIGNATURE: _____