



**FIT Wellness Center**  
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Patient's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

**ACCIDENT HISTORY 1**

**Specifics of Accident:**

- |  |   |
|--|---|
| <input type="checkbox"/> Job or Work Related Injury      | <input type="checkbox"/> Driver                       |
| <input type="checkbox"/> Front Seat Passenger            | <input type="checkbox"/> Back Seat Passenger          |
| <input type="checkbox"/> Motorcycle Driver/Passenger     | <input type="checkbox"/> Seat belted                  |
| <input type="checkbox"/> No Seatbelt                     | <input type="checkbox"/> Aware of Impending Collision |
| <input type="checkbox"/> Unaware of Impending Collision  | <input type="checkbox"/> Braced                       |
| <input type="checkbox"/> Not Braced                      | <input type="checkbox"/> Head Did Strike Object       |
| <input type="checkbox"/> Head Did Not Strike Object      | <input type="checkbox"/> Shock                        |
| <input type="checkbox"/> Loss of Consciousness           | <input type="checkbox"/> Air Bag Deployed             |
| <input type="checkbox"/> Flash of Light Seen Upon Impact |   |

**Your Vehicle** (year, make, model): \_\_\_\_\_

Your Estimated Speed at the time of Crash: \_\_\_\_\_

**Other Vehicle** (year, make, model): \_\_\_\_\_

Other Vehicle's Estimated Speed at time of Crash: \_\_\_\_\_

**Road Conditions:**

- Dry       Icy  
 Wet       Snowy

**Weather Conditions:**

- Sunny       Light Rain  
 Cloudy       Heavy Rain  
 Foggy       Snowing

**Time of Day:**

- Dawn       Day       Dusk       Night       Unknown

**Patient's Description of Accident:** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Emotions and Physical State Immediately Following the Accident:** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**ACCIDENT HISTORY 2**

**Immediately Following the Accident:**

- Ambulance/Paramedics Called to Scene
- Treated at Scene
- Transported to Hospital by Ambulance
- Went to Hospital on His/Her Own
- Diagnostics Performed at Hospital
- Treatment at Hospital
- Medication Prescribed
- Follow-up Recommended

**Other Practitioners Seen:**

- Orthopedist                       Psychiatrist/Psychologist
- Massage Therapist             Neurologist
- Physical Therapist            Other Chiropractor
- Other Practitioner

**After Accident/Hospital and First Few Days after Accident:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**SYMPTOMATOLOGY**

**Pain Characteristics for Major Area of Complaint:**

**The Pain Started:**

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**The Pain is made better by:**

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**The Pain was made worse by:**

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**The Pain has the following qualities:**

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**There is Radiation**     **There is not radiation into**

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**There is**     **There is not referred pain into**

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**There is**     **There is not paresthesia into**

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**The pain is located**

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**The pain is (as far as timing is concerned):**

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**DAILY ACTIVITIES 1**

How many days out of an average week do you have pain? \_\_\_\_\_

How much of the time out of an average day are you in pain? \_\_\_\_\_

What are the worst times of the day for the pain? \_\_\_\_\_

What are the best times of day for the pain? \_\_\_\_\_

How do the following activities affect your pain?

<u>No Change</u>	<u>Relieves</u>	<u>Increases</u>	<u>Duration</u>
<u>Sitting</u>	_____	_____	_____
<u>Walking</u>	_____	_____	_____
<u>Standing</u>	_____	_____	_____
<u>Lying Down</u>	_____	_____	_____
<u>Looking Up</u>	_____	_____	_____
<u>Looking Down</u>	_____	_____	_____
<u>Lifting</u>	_____	_____	_____

What do you do to relieve the pain? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Rating:**

Rate your pain on a scale of 1 – 10 (*10 being the worst*): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**How do you describe the overall severity of the pain?**

- \_\_\_ Mild Nuisance
- \_\_\_ Mild to Moderate but can live with it
- \_\_\_ Moderate, having trouble dealing with it
- \_\_\_ Severe, it is ruining my quality of life

**Progression:**

How is your pain compared to when the pain episode first started?

- \_\_\_ Much Improved
- \_\_\_ Much Worse
- \_\_\_ A Little Worse
- \_\_\_ No Change
- \_\_\_ Somewhat Improved

**DAILY ACTIVITIES 2**

**Your Daily Living:**

- Stay at home most of the time due to the problem
- Change positions frequently to try and get comfortable
- Walk more slowly than usual because of the problem
- Do not do jobs around the house because of the problem
- Have to use handrails to get up stairs
- Have to lie down and rest frequently due to the problem
- Have to hold onto something to sit or stand from a chair
- Have to get other people to do things for me
- Have difficulty getting dressed due to the problem
- Can only stand for short periods due to the problem
- Have difficulty bending or kneeling due to the problem
- Have difficulty turning over in bed due to the problem
- Have a loss of appetite due to this problem
- Can only walk short distances because of the problem
- Have difficulty sleeping because of the problem
- Have to get dressed with someone's help
- Have to sit most of the day because of the problem
- Am more irritable because of the problem
- Have difficulty climbing stairs
- Stay in bed most of the day because of the problem

**What are some recreational activities that you participated in before this current problem and which ones you not perform now to the same extent as before?**

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**How often do you have to stop your activities and sit or lie down to control your symptoms?**

- |   |                                       |                                |
|---|---------------------------------------|--------------------------------|
| <input type="checkbox"/> Several Times a Day        | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| <input type="checkbox"/> Approximately once per Day | <input type="checkbox"/> All Day      |                                |

**SOCIAL / OCCUPATIONAL HISTORY**

**Social History:** *(please check all that apply)*

Single       Married       Divorced      Number of Children

Smoker       Non-Smoker       Drink Alcohol       Do Not Drink Alcohol

Take Drugs       Do Not Take Drugs

Participate in the following Hobbies/Exercises:

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Occupational History: *(please check all that apply)*

Patient's Employer \_\_\_\_\_  
Job Position/Title \_\_\_\_\_

Physically Demanding Work       Any Disability Time  
 Regular Duties       Limited/Light Duties

Your Job Satisfaction:

Very Satisfied       Satisfied       Dissatisfied       Very Dissatisfied

Education Completed (Highest level of education attained):

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**MEDICAL HISTORY 1**

You have seen the following physicians and other practitioners for your current problems:

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You have received the following treatments for your problems:

- |   |   |                                      |
|---|---|--------------------------------------|
| <input type="checkbox"/> Hot Packs/Ultrasound       | <input type="checkbox"/> Chiropractic             | <input type="checkbox"/> Massage     |
| <input type="checkbox"/> Osteopathy                 | <input type="checkbox"/> Electrical Stimulation   | <input type="checkbox"/> Biofeedback |
| <input type="checkbox"/> TENS Unit                  | <input type="checkbox"/> Trigger Point Injections | <input type="checkbox"/> Aerobics    |
| <input type="checkbox"/> Body Mechanics Training    | <input type="checkbox"/> Epidural Injections      | <input type="checkbox"/> Back Brace  |
| <input type="checkbox"/> Strengthening Exercises    | <input type="checkbox"/> Acupuncture              | <input type="checkbox"/> Naturopathy |
| <input type="checkbox"/> Gravity Inversion/Traction | <input type="checkbox"/> Bed Rest                 | <input type="checkbox"/> Other:      |

You have had surgery for:

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You have been hospitalized for:

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You are taking the following medication(s):

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- You have not had any surgery                       You have not had any hospitalization  
 You are not taking any medication(s)

Number of Pregnancies \_\_\_\_

The following types of Diagnostic Testing have been performed on you:

- |                                    |                                    |                                    |                                       |
|------------------------------------|------------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> X-rays    | <input type="checkbox"/> CT Scan   | <input type="checkbox"/> Myelogram | <input type="checkbox"/> MRI Scan     |
| <input type="checkbox"/> Discogram | <input type="checkbox"/> Bone Scan | <input type="checkbox"/> EMG       | <input type="checkbox"/> Other: _____ |

You have had the following previous back, neck and musculoskeletal problems:

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**MEDICAL HISTORY 2**

You have had the following symptoms in the past 5 years:

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|--|--|
| <input type="checkbox"/> Unexplained Fevers            | <input type="checkbox"/> Swollen Ankles                    |
| <input type="checkbox"/> Night Sweats                  | <input type="checkbox"/> Stomach Pain                      |
| <input type="checkbox"/> Weight Loss of 10 lbs or more | <input type="checkbox"/> Change in Bowel Habits            |
| <input type="checkbox"/> Loss of Appetite              | <input type="checkbox"/> Persistent Diarrhea               |
| <input type="checkbox"/> Excessive Fatigue             | <input type="checkbox"/> Excessive Constipation            |
| <input type="checkbox"/> Problems with Depression      | <input type="checkbox"/> Dark Black Stools                 |
| <input type="checkbox"/> Difficulty Sleeping           | <input type="checkbox"/> Blood in Stools                   |
| <input type="checkbox"/> Unusual Stress at Work        | <input type="checkbox"/> Pain/Burning when Urinating       |
| <input type="checkbox"/> Unusual Stress at Home        | <input type="checkbox"/> Difficulty Urinating – start/stop |
| <input type="checkbox"/> Easy Bruising                 | <input type="checkbox"/> Blood in Urine                    |
| <input type="checkbox"/> Excessive Bleeding            | <input type="checkbox"/> Need to Urinate More at Night     |
| <input type="checkbox"/> Morning Stiffness             | <input type="checkbox"/> Lumps in Neck, Armpit or Groin    |
| <input type="checkbox"/> Chest Pains or Tightness      | <input type="checkbox"/> Persistent Eye Redness            |
| <input type="checkbox"/> Persistent or Unusual Cough   | <input type="checkbox"/> Muscle Tenderness                 |
| <input type="checkbox"/> Dry Eyes or Mouth             | <input type="checkbox"/> Trouble Breathing with Exercise   |
| <input type="checkbox"/> Skin Rashes                   | <input type="checkbox"/> Trouble Breathing Lying Flat      |
| <input type="checkbox"/> Coughing Up Blood             | <input type="checkbox"/> Joint Pain or Swelling            |
| <input type="checkbox"/> Other:                        |  |

**Females:**

- Vaginal Bleeding other than period
- Pap Smear within last two years
- Painful Menstrual Periods
- Back Pain with Menstrual Periods
- Other Menstrual Problems:

You feel you have trouble with:

- Anxiety                       Depression                       Irritability

Exercise Program:

- You have a home exercise program that you follow on a regular basis.
- You do not have a home exercise program that you follow on a regular basis.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_