

Ulery Wellness Center
Patient Injury/Medical History Form

Name: _____ Date: _____
Age: _____ Date of Birth: ____/____/____ M ____ F
Address: _____
City: _____ State: _____ Zip: _____
Referred by: _____
Home Phone #: _____ Work or cell #: _____
SS#: _____ Driver's License #: _____
Spouse's Name: _____
Insurance Company: _____ Name of Agent: _____
Insurance Company Phone #: _____ Agent's Phone #: _____
Claim Number: _____
Address of Insurance Company: _____
Have you retained an attorney? _____ Name, Address, Phone # of Attorney: _____

Vehicles Involved:

Your Vehicle - Year _____ Make _____ Model _____ Other Vehicle Year _____ Make _____ Model _____
Accident Type: Rear ended Head-on Broad-sided Your Speed _____ Other Vehicle Speed _____
Damage to Your Vehicle: \$ _____ Other Vehicle Damage: \$ _____
Date of accident: ____/____/____

Describe Accident: _____

Specifics of Accident (Mark each that applies to the accident):

Job or Work Related injury () Yes
Your were the Driver Passenger
Sitting Front seat Back seat
 Seat belted No seatbelt
Impending Collision Aware Unaware
 Braced Not braced
Head Did Strike Object Not strike Object
 Broken Glass
Did you experience Shock Loss of Consciousness
 Flash of Light Seen Upon Impact
Air bag Deployed

State your Emotions and Physical State *Immediately Following*
the accident:

The Road was:

Dry
 Wet
 Icy
 Snowy

The Weather Conditions were:

Sunny Light rain
 Cloudy Heavy rain
 Foggy Snowing

Immediately Following the Accident

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

Other Doctors Seen:

Orthopedist Neurologist
 Psychiatrist Physical Therapist
 Massage Therapist Chiropractor

State your Emotions & Physical State

after the first few days :

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Time of Day: Dawn Day Dusk Night Unknown

Symptomatology (Pain Characteristics for Major Area of Complaint):

The pain started _____

The pain is made better by _____

and worse by _____

The pain has the following qualities: _____

There is There is not radiation into _____

There is There is not referred pain into _____

There is There is not parasthesia (tingling/numbness) into: _____

The pain is located _____

The pain is (as far as timing is concerned: i.e. comes & goes, constant, etc.) _____

Daily Activities

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

How much time out of an average day are you in pain? _____

What are the worst times of day for the pain? _____

What are the best times of day for the pain? _____

How do the following activities affect your pain?

	No Change	Relieves	Increased	Duration
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lying Down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Looking up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Looking Down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

What do you do to relieve the pain?

Pain Rating

On a scale of 1- 10 rate your pain.

No Pain Severe Pain
0 1 2 3 4 5 6 7 8 9 10

Describe the overall severity of the pain

- Mild Nuisance
- Mild to moderate but can live with it
- Moderate, having trouble coping 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
- A little worse
- Somewhat improved
- Much worse
- No Change

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Please mark each that apply to your Daily Activities

- Stays at home most of the time due to the problem.
- Changes position frequently to try and get comfortable.
- Walks more slowly than usual because of the problem.
- Does not do jobs around the house because of the problem.
- Has to use handrails to get up stairs, etc.
- Has to lie down and rest frequently due to the problem.
- Has to hold onto something to sit or stand from a chair.
- Has to get other people to do things for you.
- Has difficulty getting dressed due to the problem.
- Can only stand for short periods due to the problem.
- Has difficulty bending or kneeling due to the problem.
- Has difficulty turning over in bed due to the problem.
- Has a loss of appetite due to the problem.
- Can only walk short distances because of the problem.
- Has difficulty sleeping because of the problem.
- Has to get dressed with someone's help.
- Has to sit most of the day because of the problem.
- Has more irritable because of the problem.
- Has difficulty climbing stairs.
- Stays in bed most of the day because of the problem.

Social History

- Single
- Married
- Divorced
- Number of Children: _____
- Smoker
- Non-Smoker
- Drinks Alcohol
- Does not drink Alcohol
- Takes Drugs
- Does not take Drugs

What are some recreational activities that you participated in before this current problem and which ones cannot be performed now to the same extent as before?

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

- Several times a day
- Occasionally
- Approximately once per day
- Never
- All Day

List your Hobbies & Exercise Activities

Occupational History

Your Employer _____

Job Title _____

Are your Job Duties Physically demanding for you? Yes No

Have you had any disability time? Yes No

If you are currently working which are you performing?

- Regular Duties
- Limited – Light Duties

What is your current job satisfaction:

- Very Satisfied
- Satisfied
- Dissatisfied
- Very Dissatisfied

Your highest level of education attained?

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Medical History

List the Physicians and other practitioners you have seen for your problem.

List the Medications you are currently taking:

List the treatments you have had for your problem.

- | | |
|---|---|
| <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"/> Body Mechanics Training | <input type="checkbox"/> Epidural Injections |
| <input type="checkbox"/> Strengthening Exercises | <input type="checkbox"/> Back Brace |
| <input type="checkbox"/> Aerobics | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Gravity Inversion – Traction | <input type="checkbox"/> Naturopathy |
| <input type="checkbox"/> Bed Rest | |

List the types of Diagnostic Testing that has been performed for this problem.

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

List Past Surgeries: None

List previous back, neck and musculoskeletal problems you have had.

List Past Hospitalizations: None

Medical History

Mark if you have had any of the following symptoms in the past 5 years.

- | | |
|--|--|
| <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"/> Lumps in neck, armpit or groin | <input type="checkbox"/> Morning stiffness |
| <input type="checkbox"/> Chest pain or tightness | <input type="checkbox"/> Persistent eye redness |
| <input type="checkbox"/> Persistent or unusual cough | <input type="checkbox"/> Muscle tenderness |
| <input type="checkbox"/> Trouble breathing with exercise | <input type="checkbox"/> Dry eyes or mouth |
| <input type="checkbox"/> Trouble breathing lying flat | <input type="checkbox"/> Skin rashes |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Joint pain or swelling |

Females – Mark if have the following:

- | |
|---|
| <input type="checkbox"/> Vaginal bleeding other than period |
| <input type="checkbox"/> Pap smear within last two years |
| <input type="checkbox"/> Painful menstrual periods |
| <input type="checkbox"/> Back pain with menstrual periods |
| <input type="checkbox"/> Other menstrual problems |

Do you have any current problem with:

- | |
|---------------------------------------|
| <input type="checkbox"/> anxiety |
| <input type="checkbox"/> depression |
| <input type="checkbox"/> irritability |

Do you have a home exercise program that you follow on a regular basis?

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|