

Chiropractic Lifecenter, Inc.
@ North Central Chiropractic
2110 N. Washington
Spokane WA 99205
509 327 4373, (fax) 509 327 1244

Name:

Date:

Place an (x) by the symptoms you are experiencing, and a #, 0-10 with 10 being the maximum pain possible by each of the pain symptoms

- | | |
|--|---|
| <input type="checkbox"/> Headache _____ | <input type="checkbox"/> Knee pain _____ |
| <input type="checkbox"/> Neck pain _____ | <input type="checkbox"/> Jaw pain _____ |
| <input type="checkbox"/> Shoulder pain _____ | <input type="checkbox"/> Visual Problems _____ |
| <input type="checkbox"/> Upper back pain _____ | <input type="checkbox"/> Dizziness _____ |
| <input type="checkbox"/> Mid back pain _____ | <input type="checkbox"/> Memory problems _____ |
| <input type="checkbox"/> Lower back pain _____ | <input type="checkbox"/> Difficulty concentrating _____ |
| <input type="checkbox"/> Chest pain _____ | <input type="checkbox"/> Depression _____ |
| <input type="checkbox"/> Arm/wrist/hand pain _____ | <input type="checkbox"/> Sleeplessness _____ |
| <input type="checkbox"/> Arm/wrist/hand numbness _____ | <input type="checkbox"/> Change in personality _____ |
| <input type="checkbox"/> Leg pain _____ | <input type="checkbox"/> Change in bowel/bladder habits _____ |
| <input type="checkbox"/> Leg numbness _____ | <input type="checkbox"/> List other symptoms _____ |

The above information is accurate

Signed _____ **Date** _____

Name: _____

Date: _____

1. What hurt immediately? _____
2. What hurt later? _____ How much later? _____
3. Were you experiencing any of the pain before this accident? _____ List pain locations below.
pain before accident (indicate 1-10) List pain locations pain after accident (indicate 1-10)

4. Were you receiving treatment for any of these complaints before the accident? _____
Name of Doctor _____ Date of last treatment _____

5. I feel my pain is due to injuries I suffered in the recent automobile accident () yes, () no.

6. Date and time of accident _____

7. Was a police report filed? _____ 8. Did police come to the scene of the accident? _____

9. Did you go to the hospital? _____ Which hospital? _____

10. Were you taken by an ambulance? _____

11. What did they do at the hospital? _____

12. Have you seen any other doctors for your injuries? _____

a. If yes, who are you seeing/have seen and what have they done? _____

13. Are you on any medications? _____ Which medications? _____

1. Describe the damage to your car? _____

2. Was your car towed? _____ 3. What was the dollar amount of damage to your car? _____

4. Where did you get the dollar amount listed in the previous question? _____

5. Make/type of car that hit you? _____

6. Make/type of your car? _____

7. Estimate how fast your car was going. _____ Were you stopped at the moment of impact? _____

8. Estimate how fast the other car was going. _____

9. Was your foot on the brake at the moment of impact? _____ Did it stay on the brake? _____

10. Were you aware of the other vehicle before impact? _____

11. The accident happened in daylight/at night. _____ What time? _____

12. The road was wet/icy/snowy/dry. _____

13. Were you sitting in the driver's seat/right front seat/left rear seat/right rear seat/other? _____

14. Were you wearing a seat belt? _____ Shoulder harness? _____ Lap Belt? _____ None? _____

15. Was your head turned on impact? _____ Turned right? _____ Turned left? _____

16. Did any part of your body strike any part of the car, including the headrest? _____

Describe the impact _____

17. What height was the headrest? Head level? _____ Neck level? _____ Shoulder level? _____

18. Did you lose consciousness? _____ Were you dazed? _____

19. Did you have any cuts? _____ Where? _____

20. Did you have any bruises? _____ Where? _____

21. Did you have any broken bones? _____ Where? _____

22. What angle was your seat at? ____ 90, ____ 105, ____ 120, ____ 135, ____ other

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PRIOR HISTORY:

1. Dates of prior automobile accidents _____ Did you receive care for your injuries? _____
If yes, who gave you your treatment? _____
What areas of the body were injured? _____
_____ What was the last date of treatment? _____

2. Have you ever had a work related injury? _____ Were you treated? _____ Where? _____
If yes, what part of your body was injured? _____

3. Have you had any other previous injuries to the areas of the body injured in this auto accident? _____
If yes, which areas of the body and when? _____

Did you receive treatment for those injuries? _____ If yes, when and where? _____

4. Have you had a recent pregnancy? _____ When? _____

5. Have you had any significant illnesses or surgeries in the past five years? _____
If yes, please list them. _____

WORK HISTORY:

1. Were you employed at the time of the accident? _____ What is your occupation? _____
2. Who is your employer? _____ Full Time ____ Part Time ____
3. At your job do you bend frequently? _____
4. Do you lift frequently? _____ What is the most weight you must lift? _____
5. Does your work aggravate your injuries? (make the pain worse) _____
6. Have you missed work because of your injuries? _____
7. If yes, what dates have you been unable to work? _____
8. Were you on the job at the time the accident occurred? _____ If yes, were you car pooling? _____
If yes, how often do you car pool? _____

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ACTIVITIES OF DAILY LIVING

Name:

Date:

Instructions:

- * Please place an "x" by each activity that causes you to have pain when you had no pain before the activity.
- * Please place an "o" by each activity that causes you to experience increased pain.

- Lifting _____ How much weight can you lift without experiencing pain, or increased pain? _____

- Walking _____ How long can you walk without experiencing pain, or increased pain? _____

- Sitting _____ How long can you sit before experiencing pain, or increased pain? _____

- Standing _____ How long can you stand without experiencing pain, or increased pain? _____

- Sleeping _____ How long can you sleep without experiencing pain, or increased pain? _____

- Driving a car _____ How long can you drive without experiencing pain, or increased pain? _____

- Washing and dressing _____

- Anything else? _____

The above information is accurate

Signed _____

Date _____

ACTIVITIES OF DAILY LIVING

Section A: For patients who have no pain before they perform the activity. Mark "x" next to true statements.

1. Lifting causes me pain _____
How much weight can you lift before experiencing pain? _____
2. Walking causes me pain _____
How long can you walk before experiencing pain? _____
3. Sitting causes me pain _____
How long can you sit before experiencing pain? _____
4. Standing causes me pain _____
How long can you stand before experiencing pain? _____
5. Sleeping causes me pain _____
How long can you sleep before experiencing pain? _____
6. Driving causes me pain _____
How long can you drive before experiencing pain? _____
7. Washing and dressing causes me pain _____

Section B: For patients who are in pain before they perform the activity

1. Lifting causes me increased pain _____
How much weight can you lift before experiencing increased pain? _____
2. Walking causes me increased pain _____
How long can you walk before experiencing increased pain? _____
3. Sitting causes me increased pain _____
How long can you sit before experiencing increased pain? _____
4. Standing causes me increased pain _____
How long can you stand before experiencing increased pain? _____
5. Sleeping causes me increased pain _____
How long can you sleep before experiencing increased pain? _____
6. Driving causes me increased pain _____
How long can you drive before experiencing increased pain? _____
7. Washing and dressing causes me increased pain _____

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Patient Name:

Date:

PAST HEALTH HISTORY:

Brief Description

approximate date

1. Dizziness
2. Backaches
3. Diabetes
4. Heart conditions
5. Arthritis
6. Headaches
7. Extremity numbness, tingling, weakness
8. Asthma
9. Nerve condition
10. Digestive Disorders
11. Cancer
12. Seizures, concussion or loss of consciousness
13. Bleeding disorders

FAMILY HISTORY:

1. Heart disease:
2. Diabetes/sugar disorders:
3. Hypertension:
4. Arthritis:
5. Cancer: