Were you born with factors which may relate to this problem? [ ] Yes [ ] No

If yes, please describe _____

_____

Do you have any previous illnesses which relate to this case? [ ] Yes [ ] No

If yes, please describe: _____

_____

Have you ever been involved in an **accident before?** [ ] Yes [ ] No

If yes, please describe, including date(s) and types of accidents and injuries received?

_____

_____

Where were you taken after the accident? _____

Have you been treated by another doctor since the accident? [ ] Yes [ ] No

If yes, please list doctor's name (and address): _____

Address _____ City _____ State _____ Zip _____

What type of treatment did you receive? _____

Did that treatment help? [ ] Yes [ ] No [ ] Not sure

Since the accident, are your symptoms: [ ] Improving [ ] Getting worse [ ] Same

Please check the symptoms you have noticed since the accident:

[ ] Headache	[ ] Irritability	[ ] Numbness in toes
[ ] Neck pain	[ ] Chest pain	[ ] Shortness of breath
[ ] Neck stiff	[ ] Dizziness	[ ] Fatigue
[ ] Sleeping problems	[ ] Head seems too heavy	[ ] Depression
[ ] Back pain	[ ] Pins & needles in arms	[ ] Light bothers eyes
[ ] Nervousness	[ ] Pins & needles in legs	[ ] Loss of memory
[ ] Tension	[ ] Numbness in fingers	[ ] Ringing in ears
[ ] Face flushed	[ ] Buzzing in ears	[ ] Loss of balance
[ ] Loss of smell	[ ] Diarrhea	[ ] Feet cold
[ ] Loss of taste	[ ] Fainting	[ ] Hands cold
[ ] Upset stomach	[ ] Constipation	[ ] Cold sweats
[ ] Fever	[ ] _____	

Symptoms other than above: _____

_____

Have you lost time from work as a result of this accident? [ ] Yes [ ] No

If yes, please complete below:

Last day worked: _____

Type of employment: _____

Present salary: _____

Are you being compensated for time lost from work? [ ] Yes [ ] No

If yes, state the type of compensation you are receiving _____

Any restrictions in your activities as a result of this injury? [ ] Yes [ ] No

If yes, please describe, in detail: _____

_____

List anything else that is pertinent to the accident or it's effect on you _____

_____

_____

PATIENT'S SIGNATURE **DATE**