

Is your condition due to an Auto Accident or Job related injury? ____ Yes ____ No

Date of Accident ____/____/____

Date of your last physical exam ____/____/____

Females: Is there any chances that you are pregnant? ____ Yes ____ No

Have you been in any automobile accidents in: ____ past 2 years ____ past 5 years ____ over 5 years

____ never: Please describe the Auto Accident: _____

Have you had any other personal injury accidents in: ____ past 2 years ____ past 5 years ____ over 5 years

____ never: Please describe the accident: _____

MARK THE AREAS ON YOUR BODY WHERE YOU HAVE SYMPTOMS. USE THE SYMBOLS BELOW.

· NUMBNESS ° PINS/NEEDLES x BURNING / STABBING

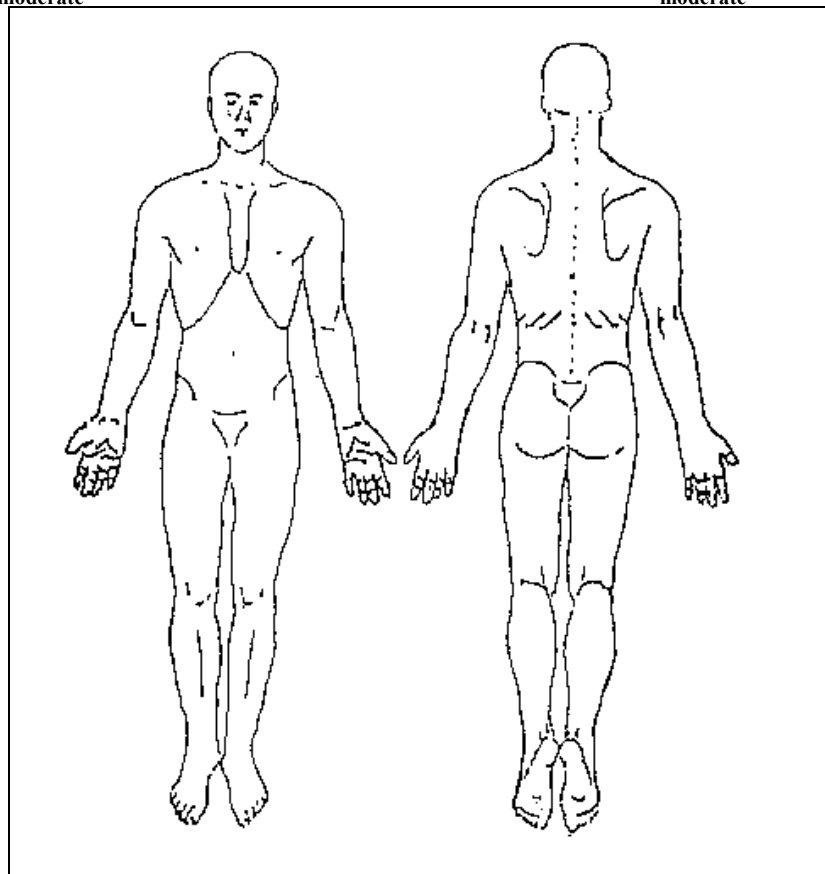
USE THE FOLLOWING SCALES TO GRADE THE INTENSITY OF YOUR PAIN

CIRCLE THE # TO INDICATE YOUR PAIN LEVEL WHEN THE PROBLEM BEGAN

CIRCLE THE # TO INDICATE YOUR PAIN LEVEL NOW

Gone 0 1 2 3 4 5 6 7 8 9 10 Unbearable
mild severe
moderate

Gone 0 1 2 3 4 5 6 7 8 9 10 Unbearable
mild severe
moderate



Patient Signature: _____ **Date:** _____