

13. What are your PRESENT complaints and symptoms? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
14. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No If yes, please describe:  
 \_\_\_\_\_  
 \_\_\_\_\_
15. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No If yes, please describe:  
 \_\_\_\_\_  
 \_\_\_\_\_
16. Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
17. Where were you taken after the accident? \_\_\_\_\_
18. Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list doctor's name and address: \_\_\_\_\_  
 \_\_\_\_\_  
 What type of treatment did you receive? \_\_\_\_\_  
 \_\_\_\_\_
19. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same
20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:
- |  |   |  |  |  |
|--|---|--|--|--|
| <input type="checkbox"/> Headache          | <input type="checkbox"/> Irritability           | <input type="checkbox"/> Numbness in Toes    | <input type="checkbox"/> Face Flushed    | <input type="checkbox"/> Feet Cold     |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands Cold    |
| <input type="checkbox"/> Neck Stiff        | <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head Seems Too Heavy   | <input type="checkbox"/> Depression          | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Constipation  |
| <input type="checkbox"/> Back Pain         | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Lights Bother Eyes  | <input type="checkbox"/> Loss of Smell   | <input type="checkbox"/> Cold Sweats   |
| <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory      | <input type="checkbox"/> Loss of Taste   | <input type="checkbox"/> Fever         |
| <input type="checkbox"/> Tension           | <input type="checkbox"/> Numbness in Fingers    | <input type="checkbox"/> Ears Ring           | <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> _____         |
- Symptoms Other Than Above \_\_\_\_\_
21. Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete this question.
- a. Last Day Worked: \_\_\_\_\_
- b. Type of Employment: \_\_\_\_\_
- c. Present Salary: \_\_\_\_\_
- d. Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, please state type of compensation you are receiving: \_\_\_\_\_
22. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No If yes, please describe, in detail:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
23. Other pertinent information: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

DATE

PATIENT'S SIGNATURE