

Welcome to our office. We strive to provide the best possible care.  
If you have any questions, please ask.

### About you:

First name: \_\_\_\_\_ Last name: \_\_\_\_\_ Middle initial: \_\_\_\_\_  
What you prefer to be called: \_\_\_\_\_  male  female Social Security: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work/Cell phone: \_\_\_\_\_  
E-mail: \_\_\_\_\_ May we email you about appointments, clinic information, billing, etc? Y N  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Work Address: \_\_\_\_\_  
Marital Status:  M  S  D  W Significant Others Name: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

### My pain is the result of:

Auto accident that occurred on \_\_/\_\_/\_\_  Work Injury that occurred on \_\_/\_\_/\_\_  
 Sports or other trauma  Chronic condition  Other: \_\_\_\_\_

Method of Payment:  Cash  Credit Card  Check  Insurance  Other \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Name of insured: \_\_\_\_\_

Insurance Address/phone: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Social Security # \_\_\_\_\_ Employer: \_\_\_\_\_

Policy#: \_\_\_\_\_ Group#: \_\_\_\_\_

Deductible: \_\_\_\_\_ Amount met: \_\_\_\_\_ Copay: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Name of insured: \_\_\_\_\_

Insurance Address/phone: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Social Security # \_\_\_\_\_ Employer: \_\_\_\_\_

If Auto accident:

You Insurance company, Policy #, Adjuster name & Telephone #:

Other Insurance company, Policy #, Adjuster name & Telephone #:

# HEALTH QUESTIONNAIRE

## Initial Evaluation

## Re-Evaluation

Marital Status: S M S D W Sex: M F # Children: 1 2 3 4 5 6 Ages \_\_\_\_\_

Patient Lives With: Alone Parents Spouse Roommate Children Assisted Living Other \_\_\_\_\_

Please mark only the complaints caused by your accident

### Patient Complaints

#### Jaw Right Left

Pain: Annoying Burning Throbbing Dull Sharp

Shooting Ache Knife like Stabbing Tightness Pressure

Numbness Tingling Other \_\_\_\_\_

#### Neck Right Left

Pain: Annoying Burning Throbbing Dull Sharp

Shooting Ache Knife like Stabbing Tightness Pressure

Numbness Tingling Other \_\_\_\_\_

#### Upper Back Right Left

Pain: Annoying Burning Throbbing Dull Sharp

Shooting Ache Knife like Stabbing Tightness Pressure

Numbness Tingling Other \_\_\_\_\_

#### Low Back Right Left

Pain: Annoying Burning Throbbing Dull Sharp

Shooting Ache Knife like Stabbing Tightness Pressure

Numbness Tingling Other \_\_\_\_\_

#### Ribs Right Left

Pain: Annoying Burning Throbbing Dull Sharp

Shooting Ache Knife like Stabbing Tightness Pressure

Numbness Tingling Other \_\_\_\_\_

Headaches? See next page

**Do you have pain in the:** (Circle those that apply)

Area between the neck and shoulder Shoulder joint Arm Elbow Wrist/Hand

Buttocks Hip Joints Legs Knees Ankles Foot

**Do you have any other complaints relatedd to the accident not covered on this form?** Please describe in detail :

**Patient:** Harry Engel 404 **Date:** 02/10/11

**Headaches: (If you are experiencing headaches fill out this section)**

Where is the pain associated with your headaches located?

Forehead      Behind eyes      Right temple      Left temple      Base of Skull      Top of head

Other: \_\_\_\_\_

On what date did your headache begin?

Date: \_\_\_\_\_ Same as neck/back complaints?      Yes      No

Please rate the intensity of your headaches:

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

What describes your pain:

Sharp      Dull      Aching      Stabbing      Deep      Vice-like      Burning      Throbbing/Pulsating

Other: \_\_\_\_\_

When do your headaches usually start?

Constant/Anytime Awake      Wake Up With In The Morning      At Midday      During Evening

What seems to bring on your headaches?

Physical Activity      Excessive Stress      Certain Foods      Caffeine      Alcohol      Menstrual Period

Other: \_\_\_\_\_

How often do they occur?

\_\_\_\_\_ x Daily      \_\_\_\_\_ x Weekly      \_\_\_\_\_ x Monthly

How long do your headaches last?

Less than 1 hour      1-3 hours      Longer than 3 hours

All Waking Hours      Several hours to days      Other: \_\_\_\_\_

Do your headaches wake you from sleep?

Yes      No      Sometimes

Do any of the following occur with your headache?

Nausea      Vomiting      Weakness      Tremor      Vision Problems

Dizziness      Light/Sound Sensitivity      Other: \_\_\_\_\_

What makes your headache better?

Nothing      Rest      Lying Down      Ice/Cold Packs      Massage

Standing      NSAIDS (aspirin, Tylenol)      Other: \_\_\_\_\_

**Patient:** Harry Engel 404 **Date:** 02/10/11

# HISTORY

Before the accident, did you have any of these complaints?

If yes, indicate below:

Neck	Upper Back	Mid Back	Low Back	Ribs	Shoulder	Arm
Forearm	Elbow	Wrist	Hands/Fingers	Buttock	Hip	Thigh
Knee	Leg/Calf	Ankle	Foot/Toes	Other:		

## Review of Systems

Are you currently suffering from any of the systems listed below?

General Fatigue	Loss of Sleep	Weight Change	Chills (continuous)	Weakness
Headaches	Dizziness	Fainting	Convulsions	Nervousness
Memory Loss	Mood Swings	Anxiety	Depression (prolonged)	Phobias (excessive fears)
Rapid Heartbeat	Chest Pain	Heart Palpitations	Heart Murmur	Abdominal Pain
Vomiting	Gas	Diarrhea	Increased Appetite	Decreased Appetite
Constipation	Heartburn	Painful Urination	Difficulty Holding Urine	Frequent Urination
Ears Ringing	Hearing Trouble	Pain in Ears	Vision Problems	Pain in Eyes

## Habits/Activities

1. Smoking: Yes No Packs per day \_\_\_\_\_
2. Drinking: Yes No Drinks per day \_\_\_\_\_
3. Caffeinated Drinks: Yes No Drinks per day \_\_\_\_\_
4. Drugs/Substance Abuse Yes No If yes, discuss with doctor
5. Exercise: How often? Never Daily \_\_\_\_ Weekly \_\_\_\_ Monthly

**Patient:** Harry Engel 404 **Date:** 02/10/11

**Health Care**

Have you ever been to a chiropractor? Yes No

Do you have a family physician? Yes No Physician's Name: \_\_\_\_\_

List Surgeries and Hospitalization:

Please list any serious accident or injury? List, date, and described injury:

Auto Accident: \_\_\_\_\_

Work Injury: \_\_\_\_\_

Sports: \_\_\_\_\_

Other: \_\_\_\_\_

List Medications and Vitamins you currently Take:

Are you allergic to any medications? Yes No Please List:

\_\_\_\_\_

Women: To your knowledge are you pregnant? Yes No

## Family History

### Father

Cancer Diabetes Heart Trouble High Blood Pressure Stroke Kidney Disease Anemia Mental Illness

Headaches Osteoporosis Arthritis Joint Problems Scoliosis Back Problems Disc Problems

Congenital Defects Genetic Disease Deceased Other: \_\_\_\_\_

### Mother

Cancer Diabetes Heart Trouble High Blood Pressure Stroke Kidney Disease Anemia Mental Illness

Headaches Osteoporosis Arthritis Joint Problems Scoliosis Back Problems Disc Problems

Congenital Defects Genetic Disease Deceased Other: \_\_\_\_\_

### Brothers/Sisters

Cancer Diabetes Heart Trouble High Blood Pressure Stroke Kidney Disease Anemia Mental Illness

Headaches Osteoporosis Arthritis Joint Problems Scoliosis Back Problems Disc Problems

Congenital Defects Genetic Disease Deceased Other: \_\_\_\_\_

### Do you currently have Conditions or Illnesses (current):

Sinus Hay fever Allergies Asthma Emphysema Tuberculosis Infection Cancer/Tumor Diabetes

Visual Disturbances Dizziness/Fainting Epilepsy/Seizures Thyroid Trouble Stroke (date)\_\_\_\_\_

High/Low Blood Pressure Heart Trouble Pacemaker Aortic Aneurysm Anemia Polio Rheumatic Fever

Multiple Sclerosis Liver Trouble Ulcer Kidney Trouble Urinary Retention Frequent Urination Prostate

Arthritis Osteoporosis Scoliosis Spinal Disc Disease Dislocated Joints Bone Fracture Mental Emotional

Difficulty HIV AIDS/ARC Abnormal Weight Gain /Loss Numbness Groin/Buttocks Fibromyalgia Chronic Fatigue

Other:

### Have you had Conditions or Illnesses (past):

Sinus Hay fever Allergies Asthma Emphysema Tuberculosis Infection Cancer/Tumor Diabetes

Visual Disturbances Dizziness/Fainting Epilepsy/Seizures Thyroid Trouble Stroke (date)\_\_\_\_\_

High/Low Blood Pressure Heart Trouble Pacemaker Aortic Aneurysm Anemia Polio Rheumatic Fever

Multiple Sclerosis Liver Trouble Ulcer Kidney Trouble Urinary Retention Frequent Urination Prostate

Arthritis Osteoporosis Scoliosis Spinal Disc Disease Dislocated Joints Bone Fracture Mental Emotional

Difficulty HIV AIDS/ARC Abnormal Weight Gain /Loss Numbness Groin/Buttocks Fibromyalgia Chronic Fatigue

Other:

**Occupational Information/Activities of Daily Living**

Are you right or left handed?            Right   Left

Job Title: \_\_\_\_\_

Job Type        Retired   Unemployed   Full Time   Part Time   Full Time Student   Part Time Student   Self-Employed

Do your present complaints affect the number of hours you work per day?   Yes   No

What movements does your job require?

Bending   Turning   Stooping   Twisting   Walking   Repetitive Hand Motion   Carrying   Other: \_\_\_\_\_

Does your job require lifting?

Never   Occasionally   Intermittently   Frequently   Constantly   Weight: \_\_\_\_\_

How do you rate your physical activity at work?

Light   Light to Moderate   Moderate   Moderate to Heavy   Heavy   Seated More than 50% of the time

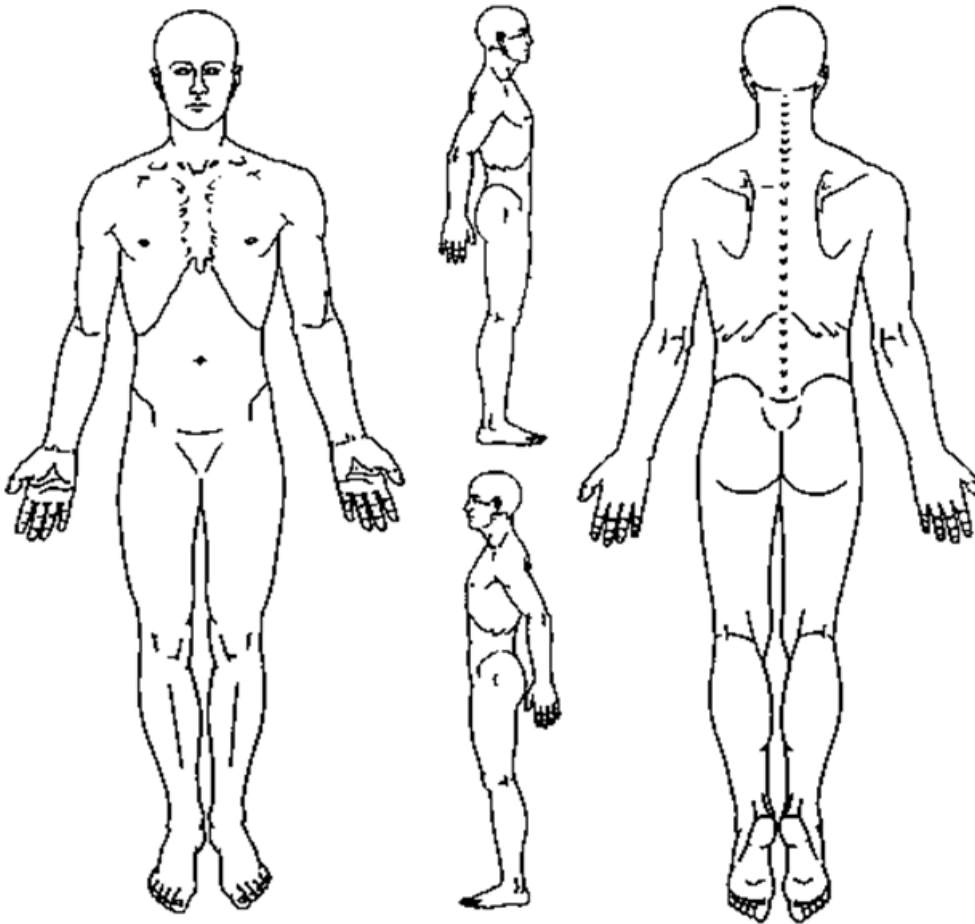
Does your work aggravate your current complaints?   Yes   No

Does your commute to work aggravate your condition?   Yes   No   Hours per day commuting \_\_\_\_\_

Has any doctor advised you to not work as a result of this accident?   Yes   No

Are you working with restrictions?   Yes   No

Please mark the location of your pain or discomfort on the images below.  
Use the symbols shown to represent the type of pain.



**A = ACHE D = DULL C = CRAMPING P = PINS & NEEDLES**  
**B = BURNING S = STABBING N = NUMBNESS O = OTHER**

**Complete this form if you have BACK PAIN:** This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem right now.**

**SECTION 1--Pain Intensity**

- A. The pain comes and goes and is very mild.
- B. The pain is mild and does not vary much.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain is severe but comes and goes.
- F. The pain is severe and does not vary much.

**SECTION 2--Personal Care**

- A. I would not have to change my way of washing or dressing in order to avoid pain.
- B. I do not normally change my way of washing or dressing even though it causes some pain.
- C. Washing and dressing increase the pain, but I manage not to change my way of doing it.
- D. Washing and dressing increase the pain and I it necessary to change my way of doing it.
- E. Because of the pain, I am unable to do any washing and dressing without help.
- F. Because of the pain, I am unable to do any washing or dressing without help.

**SECTION 3--Lifting**

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, but it causes extra pain.
- C. Pain prevents me from lifting heavy weights off the floor.
- D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
- E. Pain prevents me from lifting heavy weights , but I can manage light to medium weights if they are conveniently positioned.
- F. I can only lift very light weights, at the most.

**SECTION 4 --Walking**

- A. Pain does not prevent me from walking any distance.
- B. Pain prevents me from walking more than one mile.
- C. Pain prevents me from walking more than 1/2 mile.
- D. Pain prevents me from walking more than 1/4 mile.
- E. I can only walk while using a cane or on crutches.
- F. I am in bed most of the time and have to crawl to the toilet.

**SECTION 5--Sitting**

- A. I can sit in any chair as long as I like without pain.
- B. I can only sit in my favorite chair as long as I like.
- C. Pain prevents me from sitting more than one hour.
- D. Pain prevents me from sitting more than 1/2 hour.
- E. Pain prevents me from sitting more than ten minutes.
- F. Pain prevents me from sitting at all.

**SECTION 6 -- Standing**

- G. I can stand as long as I want without pain
- H. I have some pain while standing, but it does not increase with time.
- I. I cannot stand for longer than one hour without increasing pain.
- J. I cannot stand for longer than ½ hour without increasing pain.
- K. I can't stand for more than 10 minutes without increasing pain.
- L. I avoid standing because it increases pain right away.

**SECTION 7--Sleeping**

- A. I get no pain in bed.
- B. I get pain in bed, but it does not prevent me from sleeping.
- C. Because of pain , my normal night's sleep is reduced by less than one-quarter.
- D. Because of pain, my normal night's sleep is reduced by less than one-half.
- E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
- F. Pain prevents me from sleeping at all.

**SECTION 8--Social Life**

- A. My social life is normal and gives me no pain.
- B. My social life is normal, but increases the degree of my pain.
- C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- D. Pain has restricted my social life and I do not go out very often.
- E. Pain has restricted my social life to my home.
- F. Pain prevents me from sleeping at all.

**SECTION 9--Traveling**

- A. I get no pain while traveling.
- B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
- C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- D. I get extra pain while traveling which compels me to seek alternative forms of travel.
- E. Pain restricts all forms off travel.
- F. Pain prevents all forms of travel except that done lying down.

**SECTION 10--Changing Degree of Pain**

- A. My pain is rapidly getting better.
- B. My pain fluctuates, but overall is definitely getting better.
- C. My pain seems to be getting better, but improvement is slow at present.
- D. My pain is neither getting better nor worse.
- E. My pain is gradually worsening.
- F. My pain is rapidly worsening.

**Complete this form if you have NECK PAIN:** This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem right now.**

**SECTION 1--Pain Intensity**

- G. I have no pain at the moment
- H. The pain is mild at the moment.
- I. The pain comes and goes and is moderate.
- J. The pain is moderate and does not vary much.
- K. The pain is severe but comes and goes.
- L. The pain is severe and does not vary much.

**SECTION 2--Personal Care (Washing, Dressing etc.)**

- A. I can look after myself without causing extra pain.
- B. I can look after myself normally but it causes extra pain.
- C. It is painful to look after myself and I am slow and careful.
- D. I need some help, but manage most of my personal care.
- E. I need help every day in most aspects of self-care.
- F. I do not get dressed, I wash with difficulty and stay in bed.

**SECTION 3--Lifting**

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, but it causes extra pain.
- C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
- D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E. I can lift very light weights.
- F. I cannot lift or carry anything at all.

**SECTION 4 --Reading**

- A. I can read as much as I want to with no pain in my neck.
- B. I can read as much as I want with slight pain in my neck.
- C. I can read as much as I want with moderate pain in my neck.
- D. I cannot read as much as I want because of moderate pain in my neck.
- E. I cannot read as much as I want because of severe pain in my neck.
- F. I cannot read at all.

**SECTION 5--Headache**

- A. I have no headaches at all.
- B. I have slight headaches which come infrequently.
- C. I have moderate headaches which come in-frequently.
- D. I have moderate headaches which come frequently.
- E. I have severe headaches which come frequently.
- F. I have headaches almost all the time.

**SECTION 6 -- Concentration**

- G. I can concentrate fully when I want to with no difficulty.
- H. I can concentrate fully when I want to with slight difficulty.
- I. I have a fair degree of difficulty in concentrating when I want to.
- J. I have a lot of difficulty in concentrating when I want to.
- K. I have a great deal of difficulty in concentrating when I want to.
- L. I cannot concentrate at all.

**SECTION 7--Work**

- A. I can do as much work as I want to.
- B. I can only do my usual work, but no more.
- C. I can do most of my usual work, but no more.
- D. I cannot do my usual work.
- E. I can hardly do any work at all.
- F. I cannot do any work at all.

**SECTION 8--Driving**

- A. I can drive my car without neck pain.
- B. I can drive my car as long as I want with slight pain in my neck.
- C. I can drive my car as long as I want with moderate pain in my neck.
- D. I cannot drive my car as long as I want because of moderate pain in my neck.
- E. I can hardly drive my car at all because of severe pain in my neck.
- F. I cannot drive my car at all.

**SECTION 9--Sleeping**

- A. I have no trouble sleeping
- B. My sleep is slightly disturbed (less than 1 hour sleepless).
- C. My sleep is mildly disturbed (1-2 hours sleepless).
- D. My sleep is moderately disturbed (2-3 hours sleepless).
- E. My sleep is greatly disturbed (3-5 hours sleepless).
- F. My sleep is completely disturbed (5-7 hours sleepless).

**SECTION 10--Recreation**

- A. I am able engage in all recreational activities with no pain in my neck at all.
- B. I am able engage in all recreational activities with some pain in my neck.
- C. I am able engage in most, but not all recreational activities because of pain in my neck.
- D. I am able engage in a few of my usual recreational activities because of pain in my neck.
- E. I can hardly do any recreational activities because of pain in my neck.
- F. I cannot do any recreational activities at all.

**Date of Accident/Injury:** \_\_\_\_\_ **Time of Accident/Injury:** \_\_\_\_\_

**Description of Accident/Injury:** (circle one)

Car Accident    Work Injury    Slip and Fall    Pedestrian    Other

Were you the:    Driver                      Front Seat Passenger              Left rear Passenger              Right Rear Passenger  
Other:

Your Vehicle make and model \_\_\_\_\_ Other Vehicle Make and Model: \_\_\_\_\_

Where was your Vehicle Struck: Front    Back Left Side    Right Side

Describe in your own words what happened:  
\_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_

Amount of Damage to your vehicle \_\_\_\_\_ Was it Totaled    Driveable    Not Drivable

Amount of Damage to other vehicle \_\_\_\_\_ Was it Totaled    Driveable    Not Drivable

How many people in your vehicle: \_\_\_\_\_ How many people in the other vehicle: \_\_\_\_\_

Were the police notified? Y N    Was a police report filed? Y N

Was any party issued a citation? Y N    If yes please explain who and why:

**Patient:** Harry Engel 404 **Date:** 02/10/11



## Immediately After the Accident/Injury

Did you lose consciousness?      yes                      no                      don't know

### How did you feel?

Dazed      Dizzy      Confused      Weak      Nervous      Shocked  
Other \_\_\_\_\_

### Where did you immediately develop pain? (circle)

Head	R / L Shoulders	R / L Buttocks
Neck	R / L Arms	R / L Hips
Upper/Mid Back	R / L Elbows	R / L Thighs
Lower Back	R / L Forearms	R / L Knees
Pelvis	R / L Wrists	R / L Legs
Chest/Rib Cage	R / L Hands	R / L Ankles
Abdomen	R / L Feet	Other _____

### If there were lacerations (cuts), where?

Head	R / L Shoulders	R / L Buttocks
Neck	R / L Arms	R / L Hips
Upper/Mid Back	R / L Elbows	R / L Thighs
Lower Back	R / L Forearms	R / L Knees
Pelvis	R / L Wrists	R / L Legs
Chest/Rib Cage	R / L Hands	R / L Ankles
Abdomen	R / L Feet	Other _____

Describe any other significant injury:

## Following Accident/Injury Did Other symptoms Develop? (When?)

Headache	R / L Shoulder	R / L Thighs
Neck	R / L Hands	R / L Feet
Upper/Mid Back	R / L Elbows	R / L Knees
Lower Back	R / L Forearms	R / L Legs
Pelvis	R / L Wrist	R / L Ankles
Chest/Rib Cage	Abdomen	R / L Buttocks
Other _____		

## Since your accident/injury have you suffered from?

Blurred vision	Reduced vision	Double vision
Impaired hearing	Ringing in ears	Constipation
Diarrhea	Nausea	Vomiting
Difficulty breathing	Chest pain	Palpitations
Frequent urination	Inability to hold urine	
Painful urination		

## Additionally have you experienced any of the following?

Anxiety	Depression	Mood swings
Nervousness	Poor memory	Tension
Convulsions	Dizziness	Headaches
Fainting	Loss of balance	Fatigue
Restlessness	Difficulty sleeping	Weakness
Light Sensitivity	Reduced appetite	Weight gain
Weight loss	Other _____	

## Are you restricted in any of the following areas as a result of this accident/injury?

Daily living      Occupation/work      Recreational Activities      Other \_\_\_\_\_

**Patient:** Harry Engel 404 **Date:** 02/10/11

**Have you missed work due to this accident/injury?**

Missed work from \_\_\_\_\_ to \_\_\_\_\_  
Limited work activity from \_\_\_\_\_ to \_\_\_\_\_  
Missed no work

**Did you receive emergency care at the scene?** Yes No

Bandages Splints Brace Neck Collar Other \_\_\_\_\_

**Destination after accident injury. Where did you go?**

Hospital Home School Work Other: \_\_\_\_\_

**By whom were you driven?**

Ambulance Myself Family Friend Other \_\_\_\_\_

**Hospital / Dr. Visit After Accident/Injury?**

**When did you go to the hospital?**

Immediately Later that day Next day Other Date \_\_\_\_\_

Hospital name \_\_\_\_\_

Admitted Yes No Date discharged \_\_\_\_\_

**Lab/Blood drawn?** Yes No

**If x-rays were taken, what body part (s)?**

Head R / L Shoulder R / L Buttocks  
Neck R / L Arms R / L Hips  
Upper/Mid Back R / L Elbows R / L Thighs  
Lower Back R / L Forearm R / L Knees  
Pelvis R / L Wrists R / L Legs  
Chest/Rib Cage R / L Arms R / L Ankles  
Abdomen R / L Feet Unsure

**If a CAT Scan was performed, what body part?**

Head Upper/Mid Back Ribs/Chest Neck Lower Back Abdomen  
Other \_\_\_\_\_

**If an MRI was performed, what body part?**

Head Upper/Mid Back Ribs/Chest Neck Lower Back Abdomen  
Other \_\_\_\_\_

**What treatment was administered at the hospital?**

Oral Medication Sutures Splint Injection Ice Packs Collar  
Topical Antiseptics Support Cast Hot Packs Brace Surgery  
Bandages Other \_\_\_\_\_

**Instructions upon discharge from hospital:**

**Where you told to see:**

Doctor Practitioner Neurologist Orthopedist Other \_\_\_\_\_

**What recommendations were made?**

No follow up care Observation Support Rest Ice/Heat Collar  
Time off work Other \_\_\_\_\_

**Where medications prescribed?**

**Patient:** Harry Engel 404 **Date:** 02/10/11

Antibiotic                      Anti-inflammatories                      Pain                      Nervousness                      Other\_\_\_\_\_

**Did you self treat your symptoms?**

Over-the-counter medication                      Ice/Heat                      Bed rest  
Other \_\_\_\_\_

**Please list all Other Doctors, Specialists and Tests since the Accident**

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_

**Patient:** Harry Engel 404 **Date:** 02/10/11