NEW PATIENT HISTORY FORM (Personal Injury) Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.

Symptom 1
Ona scale from 0-10, with 10 being the worst, please circle the number that best describes your symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
 When did the symptom begin? Was the symptom the result of a motor vehicle collision? Yes No (circle one) Did you have this symptom before the motor vehicle collision? Yes No (circle one) If so, what was the intensity (0-10 w/ 10 being worst) and frequency (0-100%)
 What makes the symptom worse? (circle all that apply): Bending neck forward, bending neck backward, tilting head left, tilting head right, turning head left, turning head right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting, lifting, any movement, driving, walking, running, nothing, other (please describe):
 What makes the symptom better? (circle all that apply): Rest, ice, heat, stretching, exercise, massage, muscle relaxers, nothing Other (please describe):
 Describe the quality of the symptom (circle all that apply): Sharp, dull, achy, burning throbbing, piercing, stabbing deep nagging, shocking, stinging, Other (please describe):
Does the symptom radiate to another part of your body? (circle one): Yes No • If Yes, where does the symptom radiate:
Is the symptom worse at certain times of the day or night? (circle one): • Morning Afternoon Evening Night Unaffected by time of day
Symptom 2
Ona scale from 0-10, with 10 being the worst, please circle the number that best describes your symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
When did the symptom begin?
 Was the symptom the result of a motor vehicle collision? Did you have this symptom before the motor vehicle collision? Yes No (circle one) No (circle one)
o If so, what was the intensity (0-10 w/ 10 being worst) and frequency (0-100%)

 What makes the symptom worse? (circle all that apply): Bending neck forward, bending neck backward, tilting head left, tilting head right head right, bending forward at waist, bending backward at waist, tilting left at w tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing getting up from sitting, lifting, any movement, driving, walking, running, nothing other (please describe): 	aist,
What makes the symptom better? (circle all that apply):	
 Rest, ice, heat, stretching, exercise, massage, muscle relaxers, nothing Other (please describe): 	· · · · · · · · · · · · · · · · · · ·
 Describe the quality of the symptom (circle all that apply): Sharp, dull, achy, burning throbbing, piercing, stabbing deep nagging, shocking, so Other (please describe): 	itinging,
Does the symptom radiate to another part of your body? (circle one): Yes No • If Yes, where does the symptom radiate:	· · · · · · · · · · · · · · · · · · ·
Is the symptom worse at certain times of the day or night? (circle one):	
Morning Afternoon Evening Night Unaffected by ti	me of day
Symptom 3	
Ona scale from 0-10, with 10 being the worst, please circle the number that best describe time: 0 1 2 3 4 5 6 7 8 9 10 What percentage of the time you are awake do you experience the above symptom at the 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100 When did the symptom begin?	a abovo interests
 Did you have this symptom before the material state. 	No (circle one) No (circle one) NO%)
 What makes the symptom worse? (circle all that apply): Bending neck forward, bending neck backward, tilting head left, tilting head right, head right, bending forward at waist, bending backward at waist, tilting left at waitilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting, lifting, any movement, driving, walking, running, nothing, other (please describe): 	A
 What makes the symptom better? (circle all that apply): Rest, ice, heat, stretching, exercise, massage, muscle relaxers, nothing Other (please describe): 	
Describe the quality of the symptom (circle all that apply): • Sharp, dull, achy, burning throbbing, piercing, stabbing deep nagging, shocking, still Other (please describe):	
Does the symptom radiate to another part of your body? (circle one): Yes No If Yes, where does the symptom radiate:	

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Symptom 4							
Ona scale from 0-10, time: 0 1 2 3 4	with 10 being th 5 6 7 8 9 10	e worst, pleas	e circle the nu	mber that b	est descril	oes your sym	ptom most of th
What percentage of t 5 10 15 20	he time you are) 25 30 35 40	awake do you) 45 50 55	experience th	e above syn 75 80 85	nptom at t 90 95 10	he above int 00	ensity:
When did the sympto	m begin?					•	
	otom the result of	f a motor veh	icle collision?		Yes	No /circle	ama\
 Did you have 	this symptom be what was the int	efore the mot	or vehicle coll	ision? rst) and fred	Vac	No (circle No (circle 100%)	
What makes the symp							
 Bending neck head right, be tilting right at 	forward, bendin ending forward a waist, twisting le m sitting, lifting,	g neck backwa waist, bendir eft at waist, tw any movemer	ard, tilting hea ng backward a visting right at	t waist, tiltir waist, sittin king, runnin	ng left at w ng, standing ng, nothing	aist,	ead left, turning
What makes the symp • Rest, ice, heat Other (please	otom better? (circ , stretching, exer describe):	cise, massage	, muscle relax	ers, nothing			
Describe the quality o • Sharp, dull, ac Other (please	f the symptom (chy, burning thrologenstribe):	bing, piercing	, stabbing dee	p nagging,	shocking, s	itinging,	
Does the symptom rac • If Yes, where d	liate to another ploes the sympton	part of your bo	ody? (circle on	e): Yes	No		
s the symptom worse	at certain times	of the day or r	night? (circle o	ne)·			
Morning	Afternoon	Evening	Night		ected by ti	me of day	
ymptom 5						,	
Ona scale from 0-10, with the contract of the	6 7 8 9 10	worst, piease	circle the num	per that be	st describe	s your symp	tom most of the
Vhat percentage of the	e time you are av	vake do you e	xperience the	above symp	otom at the	e above inte	nsity:

Is the symptom worse at certain times of the day or night? (circle one):

Evening

Night

Unaffected by time of day

Afternoon

Morning

(Continued on Back)

When did the symptom begin?
Was the symptom the result of a motor vehicle collisis a 2.
Did you have this symptom before the motor vehicle collision? Ves. No. (circle one)
o If so, what was the intensity (0-10 w/ 10 being worst) and frequency (0-100%)
What makes the symptom worse? (circle all that apply):
Bending neck forward, bending neck backward, tilting head left, tilting head right, turning head left,
head right, bending forward at waist, bending backward at waist, tilting left at waist,
tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing,
getting up from sitting, lifting, any movement, driving walking rupping nothing
other (please describe):
What makes the symptom better? (circle all that apply):
Rest, ice, heat, stretching, exercise, massage, muscle relaxers, nothing
Other (please describe):
Describe the quality of the symptom (circle all that apply):
Sharp, dull, achy, burning throbbing, piercing, stabbing deep nagging, shocking, stinging, Other (places describe):
Other (please describe):
Does the symptom radiate to another part of your bask 2 ().
If Yes, where does the symptom radiate:
Is the symptom worse at certain times of the day or night? (circle one):
 Morning Afternoon Evening Night Unaffected by time of day
Symptom 6
Ona scale from 0-10, with 10 being the worst, places sizely the
Ona scale from 0-10, with 10 being the worst, please circle the number that best describes your symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
When did the symptom begin?
 Did the symptom begin suddenly or gradually ? (circle one)
How did the symptom begin?
What makes the symptom worse? (circle all that apply):
Bending neck forward, bending neck backward, tilting head left, tilting head wight to the second size t
and wallet tilling loft at walst
thung right at waist, twisting left at waist, twisting right at waist, sitting, standing
getting up from sitting, any movement, driving walking rupping nothing
other (please describe):
What makes the symptom better? (circle all that apply):
 Rest, ice, heat, stretching, exercise, massage, muscle relevers, nothing
Other (please describe):
(Continued on Back)

 Describe the quality of the symptom (circle all that apply): Sharp, dull, achy, burning throbbing, piercing, stabbing deep nag Other (please describe): 	gging, shocking, stinging,
Does the symptom radiate to another part of your body? (circle one): • If Yes, where does the symptom radiate:	Yes No
Is the symptom worse at certain times of the day or night? (circle one): • Morning Afternoon Evening Night	Unaffected by time of day

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