



# PERSONAL HISTORY

What is the most you ever weighed? \_\_\_\_\_ When? \_\_\_\_\_

Do you smoke? YES NO How much do you smoke? \_\_\_\_\_ packs/day \_\_\_\_\_ packs/week  
How long have you been a smoker? \_\_\_\_\_ Have you been a smoker in the past? YES NO  
How long have you stopped smoking? \_\_\_\_\_

Do you drink alcoholic beverages? YES NO  
How much do you drink? \_\_\_\_\_ drinks/day \_\_\_\_\_ drinks/week \_\_\_\_\_ drinks/month  
How long have you been drinking alcoholic beverages? \_\_\_\_\_ months \_\_\_\_\_ years

How many children did you give birth to? \_\_\_\_\_ What are their ages? \_\_\_\_\_

Do you commute to work? YES NO if yes, how long is the commute? \_\_\_\_\_  
What means of transportation? (Ex. Bus, drive car, carpool, walk, etc...) \_\_\_\_\_

Do you presently exercise on a regular basis? YES NO If yes, complete below:

Activity	Duration	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

List exercise activity prior to your problem:

Activity	Duration	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any known food allergies? \_\_\_\_\_

What did you eat and drink yesterday:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Do you crave certain foods: \_\_\_\_\_

Does any food you eat cause any discomfort: \_\_\_\_\_

8oz. Glasses per day

Water/day = \_\_\_\_\_ Soda/day = \_\_\_\_\_ Tea/day = \_\_\_\_\_ Other: \_\_\_\_\_

Your last bowel movement was: \_\_\_\_\_

How often do you have a bowel movement: 1x/day 2x/day 3x/day Other: \_\_\_\_\_

# PERSONAL HISTORY

Do you have, or have had, any of the following?

Problem	NO	YES	When	What
Surgery				
Surgery				
Surgery				
Cancer				
Broken Bone				
Broken Bone				
Scoliosis				
Heart Problems				
High Blood Pressure				
Stroke				
Diabetes				
Rheumatic Fever				
Rheumatoid Arthritis				
Gout				
Lupus				
Psoriasis				
Multiple Sclerosis				
Lung Problems				
Other				
Other				
Other				

# FAMILY HISTORY

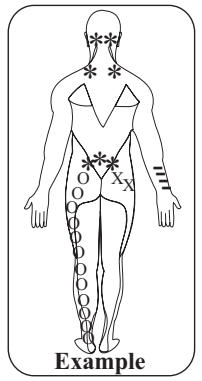
Do any of your BLOOD FAMILY have, or have had, any of the following?

Problem	NO	YES	When	What
Chronic Back Pain				
Chronic Neck Pain				
Spine Surgery				
Cancer				
Heart Problems				
High Blood Pressure				
Stroke				
Diabetes				
Rheumatic Fever				
Rheumatoid Arthritis				
Gout				
Lupus				
Psoriasis				
Multiple Sclerosis				
Lung Problems				
Scoliosis				
Other				
Other				
Other				
Other				
Other				

# PAIN CHART

Date: \_\_\_\_\_ 200

Signature: \_\_\_\_\_



**SHOW AREA(S) OF PAIN OR UNUSUAL FEELING**

Mark the areas on this body where you feel the described sensations.

Use the **appropriate symbols** (See box below)

Mark areas of **radiation** (Ex. down leg, down arm, into hip, etc.) Include **all** affected areas.

**Numbsness**

-----

**Pins & Needles**

OOOOO

**Burning**

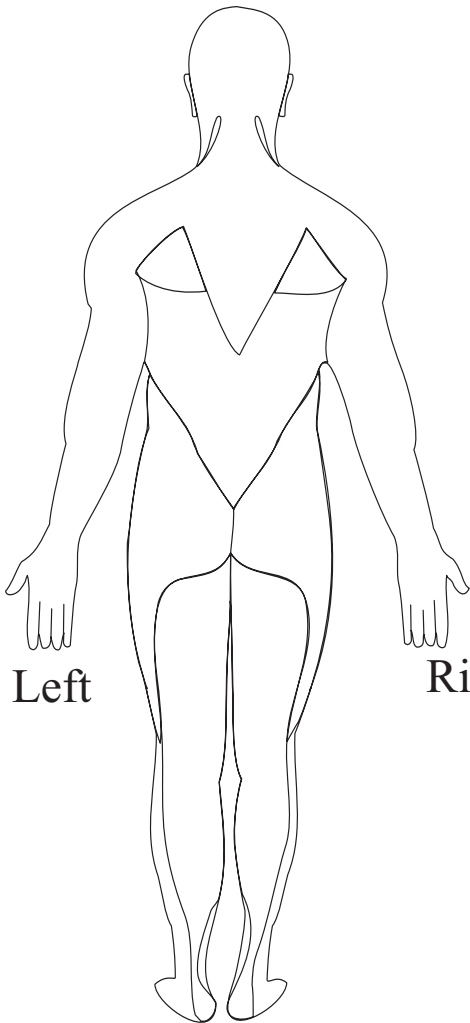
XXXX

**Aching**

\*\*\*\*\*

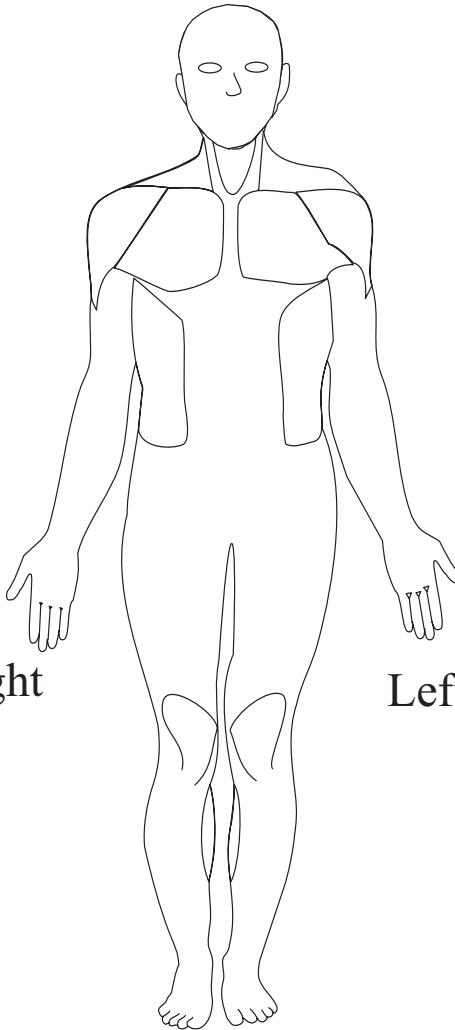
**Stabbing**

/////



Left

Right



Left

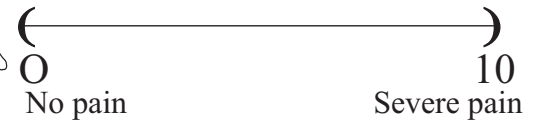
**Neck-Shoulder-Arm-Pain**

On a scale of zero to ten, I rate my discomfort as follows:



**Mid Back Pain**

On a scale of zero to ten, I rate my discomfort as follows:



**Low Back and Leg Pain**

On a scale of zero to ten, I rate my discomfort as follows:



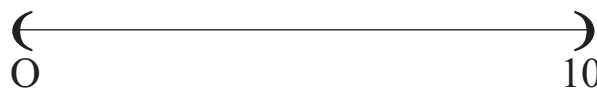
**Best You Have Felt This Week**



**Worst Pain This Week**



**Average Pain This Week**



**Please complete back side of this page**

# Symptom Questionnaire

What is your Chief/Primary Complaint? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How did this condition develop? \_\_\_\_\_  
\_\_\_\_\_  
Overexertion / Strenuous Position / Auto Accident / Work Accident / Fall / Trauma

**ONSET:** When was the first time (date) you were aware of the problem? \_\_\_\_\_

**PROV:** What makes the problem worse? \_\_\_\_\_  
Coughing/Sneezing / Lifting / Bending / Prolonged Sitting / Driving / Standing / Walking

**PALL:** What relieves the problem? \_\_\_\_\_  
Rest / Movement/Exercise / Sitting / Standing / Lying / Ice / Heat / Drugs-Aspirin / Tylenol /  
Ibuprofen / Drugs-Other: \_\_\_\_\_

**QUALITY:** How would you describe the pain or problem? \_\_\_\_\_  
Sharp / Stabbing / Dull / Aching / Burning / Throbbing / Pins & Needles / Numbness

**RADIATES:** Does this or refer into another part of your body? Left Side of / Right Side of  
Head / Neck / Shoulder / Arm / Hand / Back / Hip / Leg & Thigh / Calf / Foot \_\_\_\_\_

**TIME:** Is there any certain time of day that you notice the pain being worse?  
\_\_\_\_\_  
Morning / Afternoon / Evening / Bedtime / Wakes me up at night / At Work / After Work

How long does the pain/problem last? \_\_\_\_\_  
Brief / Intermittent / Occasional / Frequent / Constant

Have you ever had the same or similar problem before? YES NO If yes, when?  
Please explain: \_\_\_\_\_

Have you seen another doctor for this problem before? NO (YES Dr. \_\_\_\_\_)  
Recommendations or prescriptions? \_\_\_\_\_  
Please list any other medication you are currently taking. \_\_\_\_\_

Please list any vitamin or herbal supplements you are currently taking. \_\_\_\_\_  
\_\_\_\_\_

Have you ever been treated by a chiropractor before? NO (YES Dr. \_\_\_\_\_)  
Did the chiropractor adjust your Neck (Y / N), Mid Back (Y / N), Low Back (Y / N)? \_\_\_\_\_  
\_\_\_\_\_

How many times have you ever had any significant accidents (automobile or other)  
or falls? \_\_\_\_\_ As a child and/or adolescent: \_\_\_\_\_ As an adult: \_\_\_\_\_



*"Dedicated to helping you live a healthy, productive and long life"*  
**DR. RICHARD M. NOVAK**  
 Certified in Spinal Trauma

# AUTO ACCIDENT INFORMATION

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ 200  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 S.S.#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F  
 Marital Status: S/M/D/W Children: \_\_\_\_\_  
 Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Employer's Name and Address: \_\_\_\_\_  
 Name of relative not living with you: \_\_\_\_\_  
 Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Name and address of YOUR Auto Insurance Company: (Even if you were not at fault)**

Name of **YOUR** insurance carrier: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Your auto insurance agent name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_

**YOUR** attorney's name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_

Name, address, and phone # of the **OTHER** driver involved in accident in **OTHER** vehicle.

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Who was at fault in this accident: **MYSELF** **OTHER DRIVER** **DON'T KNOW**

**THEIR** automobile insurance company:

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_  
 Miscellaneous information: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Signed:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_  
 GUARANTOR OF PAYMENT



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# AUTO ACCIDENT HISTORY FORM

Your Name: \_\_\_\_\_ Date: \_\_\_\_\_ 200  
 Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_ am/pm  
 City of Accident: \_\_\_\_\_ Street of Accident: \_\_\_\_\_

Road conditions at the time of accident: **WET DRY ICY OTHER:** \_\_\_\_\_  
 Did the police come to the accident scene? **YES NO** Is there a police report? **YES NO**

Did you go to the hospital? **YES NO**  
 If yes, what is the name and city of the hospital? \_\_\_\_\_  
 How did you get to the hospital? \_\_\_\_\_  
 What parts of your body were x-rayed at the hospital? \_\_\_\_\_  
 What did the hospital do for your injuries? \_\_\_\_\_  
 How long did you stay at the hospital? \_\_\_\_\_  
 Have you seen any other doctor for this accident? **YES NO**  
 If yes, what is the doctor's name? \_\_\_\_\_

What bleeding cuts did you sustain due to this accident? \_\_\_\_\_  
 What bruises did you sustain due to this accident? \_\_\_\_\_  
 Where were you seated in the vehicle? \_\_\_\_\_  
 Were you aware of the approaching collision prior to impact, or did impact catch you by surprise? **AWARE SURPRISE**  
 Did you lose consciousness (black out) upon impact? **YES NO**

Did you become: **CONFUSED DISORIENTED LIGHT HEADED**  
**DIZZY NAUSEATED BLURRED VISION RING/BUZZ IN EARS**  
 From accident? (Please circle)  
 If you still have any of those symptoms, which ones? \_\_\_\_\_

Are you currently suffering from any of the following (please circle):  
**RESTLESSNESS IRRITABLE**  
**DIFFICULT CONCENTRATING DIFFICULT WITH MEMORY**  
**SLEEPLESSNESS FORGETFULNESS**  
**REDUCED TOLERANCE TO HEAT REDUCED TOLERANCE TO ALCOHOL**

How far was the top of the headrest or seatback from the top of your head (approximately):  
 \_\_\_\_\_ inches **ABOVE or BELOW**  
 Were you wearing your seatbelt? **YES NO**  
 If yes, was it a lap seatbelt \_\_\_\_\_ shoulder-lap seatbelt \_\_\_\_\_

Please list, make and model of the vehicle you were in:

Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_

Was your car stopped at the time of impact? **YES NO**

If yes, was the driver's foot also on the brake? **YES NO**

If no, then estimate the speed of the vehicle you were in: \_\_\_\_\_ mph

If your vehicle was moving at the time of impact, was it:

Slowing down? **YES NO** Gaining speed? **YES NO**

Traveling at a steady rate of speed? **YES NO**

On what part of the automobile did your following body parts hit?

Head hit \_\_\_\_\_ Chest hit \_\_\_\_\_

Right/left shoulder hit \_\_\_\_\_ Right/left arm hit \_\_\_\_\_

Right/left hip hit \_\_\_\_\_ Right/left leg hit \_\_\_\_\_

Right/left knee hit \_\_\_\_\_ Other \_\_\_\_\_

Did you receive any injury or bruise from the seat belt? **YES NO**

If yes, then describe: \_\_\_\_\_

Did you receive any injury or bruise from the air bag? **YES NO**

If yes, then describe: \_\_\_\_\_

Which of the following car parts broke during the accident? (Please circle)

Windshield \_\_\_\_\_ Front seat back \_\_\_\_\_

Right/left side window \_\_\_\_\_ Other \_\_\_\_\_

Steering wheel \_\_\_\_\_ Other \_\_\_\_\_

Was the trunk of your body pointed straight forward at the time of the collision?

**YES NO** If no, how was it turned? \_\_\_\_\_

Was your head pointed straight forward? **YES NO** If no, what direction was it turned

and by how much? \_\_\_\_\_

What is the year, make and model of the **other** vehicle?

Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_

Was the other vehicle moving at the time of the collision? **YES NO**

If yes, what was its approximate speed? \_\_\_\_\_ mph

If the other vehicle was moving at the time of the collision, was it (please circle):

**SLOWING DOWN GAINING SPEED TRAVELING AT A STEADY SPEED**

Please describe, to the best of your knowledge, what happened during this accident:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signed:** \_\_\_\_\_ **Today's date:** \_\_\_\_\_