NAME: _____ DATE: _____

What is being examined today? _____ Which side? (RIGHT/LEFT) _____

Were X-RAYS/MRI taken? ☐ YES ☐ NO Did you bring them in? ☐ YES ☐ NO

1. DATE of accident, **OR** HOW LONG have you had ILLNESS/PROBLEM/SYMPTONS: _____

2. BRIEFLY DESCRIBE illness/injury/symptoms requiring treatment below (@***HOW**) and include:

   a. **WHERE** it occurred: ☐ HOME ☐ SCHOOL ☐ OTHER (PLEASE SPECIFY): _____

   ☐ WORK (If so, did it occur while working for wages? ☐ YES ☐ NO ☐ UNSURE)

   ☐ MOTOR VEHICLE ACCIDENT (If so, do you have auto insurance? ☐ YES ☐ NO)

   *b. **HOW** illness/problem/symptoms/accident occurred: _____

   _____

   _____

   _____

   _____

   c. Is there a third party involved? ☐ YES ☐ NO

3. Have you seen a physician for this problem? ☐ YES ☐ NO

   a. DOCTOR: _____ ADDRESS: _____

   b. TREATMENT (special tests, injections, medications, etc.):

   _____

   _____

4. Have you had a previous problem in this area? ☐ YES ☐ NO If so, please describe:

   _____

   _____

   _____

   _____

5. Have you lost time from work because of this current injury/problem? ☐ YES ☐ NO

   If yes, DATE LAST WORKED: _____

6. Briefly describe your job activities: (lifting, pushing, pulling, driving, etc.)

   _____

   _____

7. Please describe present complaints:

   _____

   _____

   _____

   _____

   _____

8. Do you feel your symptoms are: ☐ IMPROVED ☐ MORE SEVERE ☐ REMAINED THE SAME