Thank you for carefully answering each question!

Family Friendly Chiropractic

Patient: Black ink,

Doctor: Red ink

Patient Name: _____ **Date:** _____

Work History (*Page 1*):

Employer Information:

Name of Employer: _____ **Occupation** _____

Employer Address: _____

State: _____ **Zip Code:** _____ **Work Phone:** _____

Date Injured: _____ **Time:** _____ **Last Day Worked:** _____

Accident Reported to employer? Yes ☐ No ☐ **Name of who you reported it to:** _____

Injury Location? _____

Type of work being done at time of Injury? _____

In your own words, please describe the accident? _____

_____

_____

Have you returned to work since the accident? No ☐ Yes ☐: Light Duty ☐ Reg. Duty ☐

Have you been treated/seen by another doctor for this accident? Yes ☐ No ☐

If yes, Please list names and addresses: _____

_____

Please explain the type of treatment you received: _____

_____

How long have you been treated by these doctor/s? _____

Are you: Better ☐ Unchanged ☐ Don't Know ☐

Have you had physical therapy? Yes ☐ No ☐ **If yes, How often?** _____

Thank you for carefully answering each question!

Family Friendly Chiropractic

Patient: Black ink,

Doctor: Red ink

Patient Name: _____ **Date:** _____

Work History (*Page 2*):

Information Continued:

Prior to the accident, have you ever had any of the physical complaints similar to what you have now? Yes ☐ No ☐

If Yes: Were these similar complaints the result of a previous accident? Yes ☐ No ☐

If yes: Please describe the details of the accident: _____

_____

Have you had any other serious accidents that required medical attention? Yes ☐ No ☐

If yes: Please explain: _____

Have you had any serious illnesses that required hospitalization? Yes ☐ No ☐

If yes: Please explain: _____

Have you had any surgeries? Yes ☐ No ☐ **If yes, Please describe what and when:** _____

_____

Have you had any nervous or mental illness? Yes ☐ No ☐ **If yes, Please describe:** _____

_____

Have you have any psychiatric care? Yes ☐ No ☐

Have you received a medical discharge from the Armed Forces? Yes ☐ No ☐

Back Pain:]

I currently have pain in my: Lower Back ☐ Mid Back ☐ Upper Back ☐

My pain began: Gradually ☐ Suddenly ☐ **I have pain:** All of the time ☐ Sometimes ☐

My pain goes into: Right leg ☐ Left leg ☐ Both ☐

I have tingling and/or numbness in my : Right leg ☐ Left leg ☐ Both ☐

My pain gets worse when I: Cough ☐ Sneeze ☐ Sit ☐ Bend ☐ Walk ☐ Lift ☐ Push ☐ Pull ☐

My Back gets worse with sexually activity? Yes ☐ No ☐

My pain wakes me up in the middle of the night? Yes ☐ No ☐

Changes in the weather affect my pain? Yes ☐ No ☐

Thank you for carefully answering each question!

Family Friendly Chiropractic

Patient: Black ink,

Doctor: Red ink

Patient Name: _____ **Date:** _____

Work History (*Page 3*):

Thank you for taking the time to fill out this questionnaire. This information is important in the doctor obtaining a clinical picture so as to make an appropriate diagnosis & treatment plan. Please sign below authorizing that the information in this form has been read & filled out completely & accurately to the best of your understanding. Also, understand that the information in this form is considered confidential & for use by your doctor at Neurological Rehabilitation Center LLC. Any disclosure is outlined in our privacy policies.

Patient's signature (*or guardian's signature*) _____ Date _____

Patient's print (*or guardian's print name*) _____

Signature of translator or person assisting with this form (*if any)* _____

Printed name of said person _____ Date _____

Thank you for carefully answering each question!

Family Friendly Chiropractic

Patient: Black ink,

Doctor: Red ink

Patient Name: _____ Date: _____

Work History (*Page 4*):