# PATIENT INFORMATION Part 1 *(Please print in dark ink.)*

**Today's date** _____ **Translator** _____

**Name** _____ **Height** _____ **Weight** _____

**Address** _____ **Date of birth** _____ **Age** _____

_____ **Injury date** _____**Claim** _____

**Phone** _____ **Right or left-handed?** _____

**Accompanied by** _____ **Male** ____ **Female**___**Pregnant?** Y N

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**Employer when injured** _____ **Occupation** _____

**Present employer** _____ **Occupation** _____

**Prior claims or car accidents (year & injury)** _____

**Previous injuries/illnesses (type & year)** _____

**Previous surgeries/hospitalizations**_____

_____

**Allergies** _____

**Present medications** _____

**Other drug use?** Y N **Frequency?** _____/week **Type** _____

**Tobacco?** Y N **Years used?** _____ **Type** _____ **Amount** _____

**Alcohol?** Y N **Drinks per week** _____ **Caffeine?** Y N **Cups per day?** _____

**Medical conditions in your family?** _____

**Marital status** _____ **# of children** _____ **# dependent children** _____

**Highest grade completed** _____ **GED** _____ **Degrees** _____

**Military service?** Y N **Branch** _____ **How long?** _____

**Are you being treated for any other conditions?** Y N *If none, please list your current doctor.*

| **Condition** | **Doctor** |
|---|---|
| | |

# PATIENT INFORMATION Part 2 Claim # _____

**Main complaints** _____

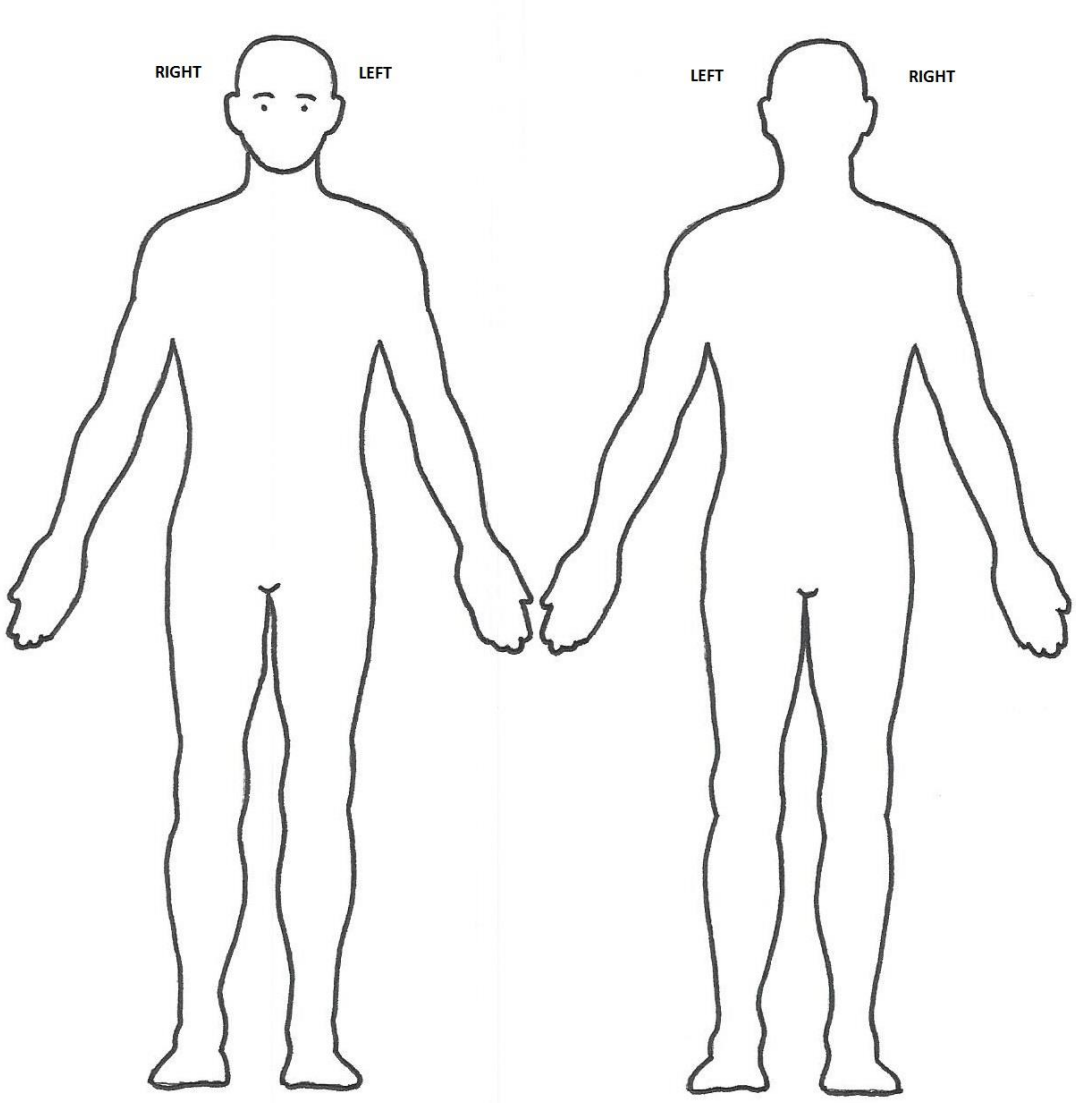
_____

**In the list below, please circle areas where you are currently having symptoms:**

| | | | |
|---|---|---|---|
| Eyes | Breathing | Bones | Urination |
| Ears | Heart | Muscles | |
| Nose and/or throat | Stomach | | |

**On the body outline below, use the following letters to indicate your symptoms:**

B = Burning S = Stabbing A = Aching N = Numbness T = Tingling




**On a scale of 1 to 10 (1 being no pain and 10 being intolerable pain), indicate the number that best describes your pain level:** Today _____/10_

Lowest ever _____/10 Lowest in last two weeks_____/10

Highest ever ____/10 Highest in last two weeks_____/10