Chiropractic & Natural Health

Aspenridge
CHIROPRACTIC CENTER, P.A.

PERSONAL INJURY REPORT

Name _____ Phone ( ) _____
Address _____ City _____ MN _____ Zip _____
Age _____ Birthdate _____ Sex ___ SS# _____

Responsible Party's Name _____
Address _____ City _____ State _____ Zip _____

Insurance Carrier _____
Address _____ City _____ State _____ Zip _____
Claim # _____

NATURE OF ACCIDENT:

1. Date of injury _____ Time of Day _____
2. In your own words, describe what happened: _____
3. Did you have any physical complaints before the accident? __ Yes __ No If yes, please explain: _____
4. Please describe how you felt:
   a. DURING the accident: _____
   b. IMMEDIATELY AFTER the accident: _____
   c. LATER THAT DAY: _____
   d. THE NEXT DAY: _____
5. What are your PRESENT complaints and symptoms? _____
6. Do you have congenital (from birth) factors which relate to this problem? __ Yes __ No If yes, please describe: _____
7. Do you have a previous illness which relates to this injury? __ Yes __ No If yes, please describe: _____
8. Where were you taken after the injury? _____
9. Have you been treated by another doctor since the injury? __ Yes __ No If yes, please list doctor's name and address: _____
   What type of treatment did you receive? _____
10. Since the injury occurred, are your symptoms: __ Improving __ Getting Worse __ Same

2511 WASHINGTON AVE. CLOQUET, MN 55720 218-879-5831 FAX: 218-879-0517

11. Have you lost time from work as a result of this accident? __ Yes __ No If yes, please complete these questions:

a. Last Day Worked: _____

b. Type of Employment: _____

c. Are you being compensated for time lost from work? __ Yes __ No If yes, please state type of compensation you are receiving: _____

12. Do you notice any activity restrictions as a result of this injury? __ Yes __ No If yes, please describe in detail: _____

CURRENT MEDICAL COMPLAINTS

BACK PAIN:

1. Currently, I have pain in my:	( ) low back	( ) mid back	( ) upper back
2. My pain began:	( ) gradually	( ) suddenly	
3. I have pain:	( ) sometimes	( ) all of the time	
4. My pain goes into my:	( ) right leg	( ) left leg	( ) both
5. I have tingling and/or numbness in my:	( ) right leg	( ) left leg	( ) both
6. My pain is worse when I:			
cough or sneeze	( ) Yes	( ) No	
sit	( ) Yes	( ) No	
bend	( ) Yes	( ) No	
walk	( ) Yes	( ) No	
lift	( ) Yes	( ) No	
push	( ) Yes	( ) No	
pull	( ) Yes	( ) No	
7. My back is worse with sexual activity	( ) Yes	( ) No	
8. My pain wakes me up during the night	( ) Yes	( ) No	
9. Changes in the weather affect my pain	( ) Yes	( ) No	

NECK PAIN:

1. My neck pain began:	( ) gradually	( ) suddenly	
2. I have pain:	( ) sometimes	( ) all of the time	
3. My pain goes into my:	( ) right arm	( ) left arm	( ) both
4. I have tingling and/or numbness in my:	( ) right arm	( ) left arm	( ) both
5. My pain is worse when I:			
cough or sneeze	( ) Yes	( ) No	
bend forward	( ) Yes	( ) No	
lift	( ) Yes	( ) No	
push	( ) Yes	( ) No	
pull	( ) Yes	( ) No	
turn my head	( ) Yes	( ) No	
6. My pain wakes me up during the night	( ) Yes	( ) No	
7. Changes in the weather affect my pain	( ) Yes	( ) No	
8. I have neck stiffness	( ) Yes	( ) No	
9. I have headaches	( ) Yes	( ) No	
10. If I do get headaches, they occur:	( ) sometimes	( ) all of the time	

OTHER PAIN:

Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition:

_____

_____ _____

Patient's Signature Date