NAME: _____

Did you have any physical complaints before this accident: () Yes () No, If yes please describe_____

Please describe how you felt:

A. DURING the accident:_____

B. IMMEDIATELY after the accident:_____

C. LATER that day: _____

D. THE NEXT day: _____

What are your PRESENT complaints and symptoms?_____

_____

Do you have any congenital? (From birth) factors which relate to the problem? () Yes () no If yes, please describe: _____

_____

Do you have any previous illnesses, which relate to this case? () Yes () no If yes, please describe:_____

_____

Have you ever been involved in an accident, previous? () yes () no If yes, please describe, including dates and type of accident, as well as injury (ies) received:_____

_____

Have you lost time from work as a result of this accident? ()yes ()no last day worked_____

_____

Do you notice any activity restrictions as a result of this injury? ()yes ()no if yes, please Describe_____

_____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

Headache ()	Irritability ()	Shortness of breath ()
Fatigue ()	Neck Pain ()	Chest Pain ()
Loss of balance ()	Fainting ()	Neck Stiff ()
Dizziness ()	Loss of smell	Diarrhea () Constipation ()
Sleeping Problems ()	Head seems heavy ()	Lights bother eyes ()
Fever ()	Back Pain ()	Pins and needles in arms ()
Loss of Memory ()	Shoulder ()	Shoulder Pain ()
Pins and needles in legs ()	Ears ring ()	Nervousness ()
Numbness in Fingers ()	Face flushed ()	Feet Cold ()
Tension ()	Numbness in toes ()	Buzzing in ears ()

Symptoms other than above:_____

Draw a DIAGRAM of the accident:

Patient's signature:_____Date:_____