LEVIN and CHELLEN CHIROPRACTIC
4144 COUNTY ROAD 101, MTKA, MN 55345
(952) 474-1777

MOTOR VEHICLE ACCIDENT and PERSONAL INJURY PATIENT HEALTH QUESTIONNAIRE

Name _____ Date _____ Occupation _____

Age _____ Birthdate _____ Sex: M F Previous Chiropractor, if any: _____

Present Concern(s): What bothers you most? _____

Next most? _____

Next? _____

Other / Comments: _____

For the questions below, please answer for the condition you indicated bothers you most.

When did your symptoms first appear? _____

What have you done to TRY to relieve your symptoms? _____

What have you done that WORKS to relieve your symptoms? _____

What makes your symptoms worse? _____

Where exactly does the pain or symptoms occur? _____

What is the quality of the pain? ☐ Sharp ☐ Dull ☐ Aching ☐ Throbbing ☐ Burning ☐ Numbness/ tingling

☐ Other: _____

Does the pain radiate into another body area? YES NO If yes, where? _____

Do you experience any symptoms when coughing, sneezing, laughing or having a bowel movement? Yes No

Do you experience any weakness, pain, numbness, tingling, burning, or other abnormal sensations in your arms, hands, fingers, legs, feet, or toes? Yes (please circle symptoms and parts) No

How frequent are the symptoms present? ☐ Constant (76-100%) ☐ Occasional (26-50%)
☐ Frequent (51-75%) ☐ Intermittent (25% or less)

How long does the pain last? ☐ A few minutes ☐ A few hours ☐ A few days ☐ Comes and goes ☐ Constant

When does the pain occur? ☐ Upon waking ☐ Daytime ☐ Nighttime ☐ Depends on position ☐ Other: _____

Is your pain: ☐ Mild ☐ Moderate ☐ Considerable ☐ Severe

How did your problem begin? ☐ Gradually developed ☐ Immediately after a specific incident ☐ After multiple incidents

Mechanism of Injury: ☐ Fall ☐ Lifting ☐ Sports related ☐ Work related ☐ Auto accident

☐ Other: _____

Please circle the number or numbers which reflect the severity of your pain : 0 1 2 3 4 5 6 7 8 9 10

Since your problem began, is it: ☐ Increasing ☐ Decreasing ☐ No change

Please mark on the picture, using letters below,
to indicate the type and location of your sensations or symptoms.

(please include all areas of discomfort)

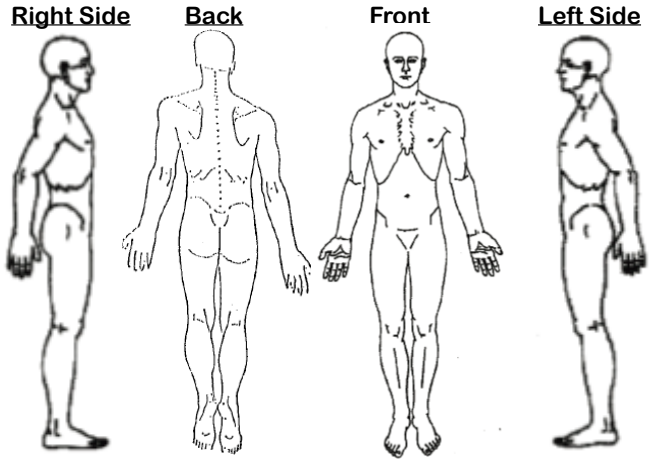
A = Ache S = Stabbing or Sharp

B = Burning D = Dull

N = Numbness X = Tingling

T = Throbbing Z = Other

W = Weakness



Have you seen any other health care providers for this condition? YES NO

Date Name Phone Number

Thank you for answering the following questions. A complete understanding of your health status will facilitate proper evaluation and treatment of your complaints.

PAST HISTORY

List any previous injuries (slips, falls, auto accidents, sports injuries, broken bones, etc., and give dates.

Have you had previous neck or back problems? YES NO If so, describe and give dates.

List any past significant illnesses and give dates:

List any allergies:

Are you under another doctor's care for any reason? YES NO If so, give name and condition.

List all surgeries and hospitalizations and give dates.

YEAR PROBLEM HOSPITAL or CLINIC

Are you taking any medications? (Prescription or Non-prescription) If so, please list name and condition treated.

FAMILY HISTORY

Is there a FAMILY history of serious illness? YES NO If yes, please explain:

Do YOU have a history of cancer or any other serious disease such as liver, lung, heart, kidney, bladder, bowel, thyroid, diabetes, high blood pressure, stroke, hepatitis, or HIV? YES NO If yes, please explain:

Do you have shortness of breath when NOT exerting yourself? Yes No Do you now or have you recently had a fever? Yes No

Do you have a phlegm producing cough? Yes No If yes, what color is it?

Do you have recent hearing changes? Yes No If yes, please explain:

Do you have recent visual changes Yes No If yes, please explain:

Do you have nausea? Yes No If yes, please explain:

Do you have difficulty controlling your bowel or bladder? Yes No If yes, please explain:

Do you have stomach upset with certain foods? Yes No If yes, please explain:

Do you have indigestion after meals? Yes No If yes, please explain:

Do you have a recent change in sexual ability? Yes No If yes, please explain:

Have you had a recent unexplainable weight change? (gaining or losing) Yes No If yes, please explain: