KRUSE CHIROPRACTIC

EXAM
PATIENT HISTORY

Incident: PI WC Group Cash MC

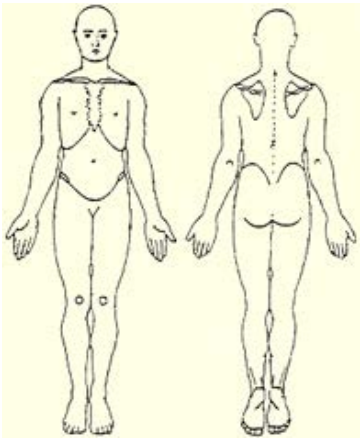
Insurance:_____

_____
Today's Date (MM/DD/YYYY)

_____ _____ _____
Last Name First Name Middle Name (Initial)

1. **What symptoms prompted you to seek care today?**_____

2. **When did these symptoms start? How did they start?**_____



3. **Quality of Symptoms**(What does it feel like?)
- ◯ Numbness
- ◯ Tingling
- ◯ Tightness
- ◯ Dull
- ◯ Aching
- ◯ Cramps
- ◯ Heavy
- ◯ Sharp
- ◯ Burning
- ◯ Shooting
- ◯ Throbbing
- ◯ Stabbing
- ◯ Other

4. **Intensity** (How extreme symptoms)
0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Absent Uncomfortable Agonizing

5. **Duration & Timing** (how often do you feel it?)
◯Constant ◯ Comes and goes

6. **Radiation** (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)
_____

7. **Aggravating or Relieving Factors** (What make it better or worse, such as time of day, movements, activities, etc.)
What tends to lessen the problem?_____
What tends to worsen the problem? _____

8. **Prior Interventions** (What have you done to relieve the symptoms?)
- ◯ Prescription medication
- ◯ Over-the-counter drugs
- ◯ Chiropractic
- ◯ Ice
- ◯ Heat
- Other_____

9. **What else should we know about your current condition?**_____
_____
_____

10. **Review of systems** (Identify any changes since your most recent evaluation with us)

		Current	Past	None
a.	**Musculoskeletal System-**osteoporosis, arthritis, neck pain, back problems, poor posture	◯	◯	◯
b.	**Neurological System-**anxiety, depression, headache, dizziness, pins & needles, numbness	◯	◯	◯
c.	**Cardiovascular System**-high blood pressure, low blood pressure, high cholesterol, chest pain	◯	◯	◯
d.	**Integumentary System**-skin cancer, psoriasis, eczema, acne, hair loss, rash	◯	◯	◯
e.	**Genitourinary System**-kidney stones, infertility, bedwetting, prostate issues, PMS symptoms	◯	◯	◯
f.	**Constitutional System**-fainting, low libido, poor appetite, fatigue, sudden weight, weakness	◯	◯	◯
g.	**Lymphatic System**-swelling or pain in lymph nodes of neck, axillae, groin & other areas	◯	◯	◯

11. **Prior illnesses, operation, injuries or treatments:**_____
_____
_____

12. **Social History** (Tell Kruse Chiropractic about your health habits)
Allergies:_____
(203)Tobacco Use:_____

13. **Medications/Supplements:**_____
_____

14. **Goals/Problems**_____
_____

- ◯ Date of Incident _____
- ◯ Reported? Y N
  Whom? _____
- ◯ Health Insurance Card
- ◯ Relationship to Policy: _____
- ◯ SSN: _____
- ◯ Supplemental Insurance
- ◯ Employer _____
  Phone _____

CHARGES

AUTO ONLY

Describe what happened:

_____

Direction of impact came from? ◯Front ◯Rear ◯Right Side ◯Left Side ◯Other

Number of peope in the accident: _____

Date of Injury_____Time:_____AM / PM

Did you lose consciousness? ◯ Yes ◯ No

Where did you go after the incident? ◯ Home ◯ Work ◯Hospital/Acute Care

Was a police report made? ◯ Yes ◯No

Were you the: ◯ Driver ◯ Front Seat Passenger ◯ Rear Seat Passenger

To Whom: _____

Position of Patient: ◯ Looking Down ◯ Turned R / L ◯ Looking Forward

_____

Your Vehicle was: ◯ Accelerating ◯ Decelerating ◯ Stopped

_____

Their Vehicle was: ◯ Accelerating ◯ Decelerating ◯ Stopped

_____

Head Restraints: ◯ Up ◯ Down ◯ Unsure

_____

Was the seat altered by the impact? ◯ Yes ◯ No

Describe vehicle's:_____

What type of seatbelt was it? ◯ **3-position** Belt ◯ Shoulder Harness ◯ Not Wearing

_____

Were you aware of the impending collision? ◯ Yes ◯ No

_____

Did the airbags deploy? ◯ Yes ◯ No Did the airbag strike you? ◯ Yes ◯ No

_____

Did you strike any parts of the vehicle? ◯ Yes ◯ No If yes, what struck you & where?_____

WC/PI ONLY

Date of Injury_____Time:_____ AM/PM

Who saw the accident? Name:_____ Title:_____

Who reported the accident? Name:_____ Title:_____

Describe the accident:

_____

Do you use hand or foot levers: ◯Yes ◯ No

Do you work overhead: ◯Yes ◯No

Do you have to reach: ◯Yes ◯No

Explain:_____

Is your area cluttered: ◯Yes ◯No

Explain:_____

Do you push or pull: ◯Yes ◯No

Explain:_____

Do you pick up or pull: ◯Yes ◯No

How much:_____ How often:_____

Do you use a cart: ◯Yes ◯No

Type of wheels: ◯Rubber ◯Steel ◯Plastic

Condition of the cart: ◯Good ◯Bad ◯Other: _____

# of carts moved at once: _____ Weight per cart:_____

From where to where:_____

Do you lift in/out of a machine: ◯Yes ◯ No

If so, do you: ◯Sit ◯Stand ◯Kneel

WORKPLACE INFO

Type of flooring: ◯Rough ◯Smooth ◯Wood ◯Concrete ◯Steel ◯Other:_____

Type of ventilation: ◯Blower ◯A/C ◯Heat ◯Exaust ◯None ◯Other:_____

Type of lighting: ◯Overhead ◯Flourescent ◯On Machinel ◯Other:_____

Is your work area: ◯Oily ◯Dirty ◯Slippery ◯ Other:_____

Has outside help been hired: ◯Yes ◯No If yes, why?:_____

Type of windows: ◯Open ◯Closed ◯No Windows

Type of Shop: ◯Union ◯Non-Union

Tired at end of day: ◯Yes ◯No

Have you seen any other doctors: ◯ Yes ◯ No

When did you go? ◯ Immediately ◯ Next Day ◯ 2 Days Plus

How did you get there: ◯Ambulence ◯Someone else ◯Self

Was medication prescribed: ◯Yes ◯No

Name of Hospital and/or attending doctor: _____

Was he/she a: ◯D.D.S. ◯M.D. ◯D.C. ◯D.O. ◯PA

Were any X-rays taken? ◯Yes ◯No

Have you been able to work since this injury? ◯Yes ◯No

Are you working with restrictions due to this inmjury? ◯Yes ◯No

Have you retained an attorney: ◯ Yes ◯ No If yes, Who:_____Phone:_____

Additional Notes: