



# ZYGMONT CHIROPRACTIC

## Personal Injury patient history

Check symptoms present since the accident:

- |  |  |  |   |                                       |
|--|--|--|---|---------------------------------------|
| <input type="checkbox"/> Neck pain/stiffness | <input type="checkbox"/> Numbness in toes  | <input type="checkbox"/> Ringing/buzzing ears    | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Cold sweats  |
| <input type="checkbox"/> Midback pain        | <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Fainting                | <input type="checkbox"/> Irritability   | <input type="checkbox"/> Nervousness  |
| <input type="checkbox"/> Low back pain       | <input type="checkbox"/> Nausea            | <input type="checkbox"/> Eyes sensitive to light | <input type="checkbox"/> Depression     | <input type="checkbox"/> Chest pain   |
| <input type="checkbox"/> Headache            | <input type="checkbox"/> Fatigue           | <input type="checkbox"/> Pain behind eyes        | <input type="checkbox"/> Diarrhea       | <input type="checkbox"/> Anxious      |
| <input type="checkbox"/> Arm pain            | <input type="checkbox"/> Tension           | <input type="checkbox"/> Loss of smell           | <input type="checkbox"/> Cold hands     | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Leg pain            | <input type="checkbox"/> Loss of Balance   | <input type="checkbox"/> Loss of taste           | <input type="checkbox"/> Cold feet      |                                       |
| <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Shortness of breath     | <input type="checkbox"/> Other _____    |                                       |

### WORK HISTORY:

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Have you missed time from work as a result of the accident?  Yes  No

If yes: Full time off work: \_\_\_\_\_ to \_\_\_\_\_ to \_\_\_\_\_

If yes: part time off work: \_\_\_\_\_ to \_\_\_\_\_ to \_\_\_\_\_

Not able to work since accident

### FIRST DOCTOR/HOSPITAL/CLINIC VISITED:

Did you seek medical help immediately/soon after the accident?  Yes  No

If yes, how did you get there?  Ambulance  Police  Someone else drove me  Drove my own vehicle

Doctor 1/Hospital/Clinic Visited: \_\_\_\_\_

Were you examined?  Yes  No Were X-rays taken?  Yes  No

Were you treated or given medication?  Yes  No

If yes, what treatment/medication was given to you? \_\_\_\_\_

What benefits did you receive from the treatment? \_\_\_\_\_

Date of last treatment: \_\_\_\_\_

### SECOND DOCTOR/HOSPITAL/CLINIC VISITED:

Doctor 2/Hospital/Clinic Visited: \_\_\_\_\_

Were you examined?  Yes  No Were X-rays taken?  Yes  No

Were you treated or given medication?  Yes  No

If yes, what treatment/medication was given to you? \_\_\_\_\_

What benefits did you receive from the treatment? \_\_\_\_\_

Date of last treatment: \_\_\_\_\_

### THIRD DOCTOR/HOSPITAL/CLINIC VISITED:

Doctor 3/Hospital/Clinic Visited: \_\_\_\_\_

Were you examined?  Yes  No Were X-rays taken?  Yes  No

Were you treated or given medication?  Yes  No

If yes, what treatment/medication was given to you? \_\_\_\_\_

What benefits did you receive from the treatment? \_\_\_\_\_

Date of last treatment: \_\_\_\_\_

### PRIOR IDENTICAL SYMPTOMS:

Did you have any physical conditions just before the accident?  Yes  No

If yes, please describe in detail: \_\_\_\_\_

PRIOR to this accident, have you ever had symptoms similar to what your experiencing now?  Yes  No

If yes, please explain: (briefly include; accidents, injuries, operations, past falls, etc.) \_\_\_\_\_

\_\_\_\_\_