Welcome **Patient Demographics**

PATIENT INFORMATION			
Patient Name:		**DOB:**	☐ M ☐ F
Address:		**SSN:**	
City:		**State:**	**Zip:**
Driver's License #	**State:**	**Cell Phone:**	
Email Address:		**Home Phone:**	
Primary Care Physician:		**Phone:**	
Emergency Contact:		**Phone:**	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other			
How did you hear about us? ☐ Google ☐ Yelp ☐ Attorney ☐ Other (explain)			
Would you like our help in finding a Personal Injury Attorney? ☐ Yes ☐ No			

INJURY INFORMATION	
Date of Onset:	**Type of Injury:** ☐ Motor Vehicle ☐ Work ☐ Sports ☐ Other (explain)

INSURANCE INFORMATION – RESPONSIBLE PARTY		
Company:	**Claim #**	
Address:	**Group #**	
City:	**State:**	**Zip:**
Adjuster:	**Phone:**	
	Fax:	

ATTORNEY INFORMATION		
Name:	**Phone:**	
Address:	**Fax:**	
City:	**State:**	**Zip:**
Did the Police make an Accident Report? ☐ Yes ☐ No	**Report #**	

EMPLOYER INFORMATION		
Employment Status: ☐ Employed Full-Time ☐ Employed Part-Time ☐ Unemployed ☐ Student		
Company:	**Phone:**	
Address:	**Fax:**	
City:	**State:**	**Zip:**
Supervisor's Name:	**Reported to Supervisor?** ☐ Yes ☐ No ☐ N/A	
Medical Rep:	**Phone:**	
Job Description:		

FINANCIAL RESPONSIBLE PERSON			
Name:	**Relationship:**	**SSN:**	**DOB:**
Address:		**Phone:**	

I AUTHORIZE INSURANCE BENEFITS TO BE **PAID DIRECTLY TO TEXAS INJURY CLINIC**. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR MY BALANCE**. I AUTHORIZE TEXAS INJURY CLINIC OR MY INSURANCE TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIM.

______________________________ **Signature of Patient or Legal Guardian**

______________ **Date**

______________________________ **Printed Name of Patient or Legal Guardian & Relationship to Patient**

SELF-ASSESSMENT

Print Name:

Chief Complaint(s) / History of Current Condition

Symptom(s)	Side	Severity	Pain Quality	Date of Onset	Frequency
Headache	❑ Left ❑ Right	❑ Mild ❑ Moderate ❑ Severe	❑ Dull ❑ Radiating ❑ Sharp ❑ Tingling		❑ Constant ❑ Daily ❑ Intermittent ❑ Occasional
Neck Pain	❑ Left ❑ Right	❑ Mild ❑ Moderate ❑ Severe	❑ Dull ❑ Radiating ❑ Sharp ❑ Tingling		❑ Constant ❑ Daily ❑ Intermittent ❑ Occasional
Middle Back Pain	❑ Left ❑ Right	❑ Mild ❑ Moderate ❑ Severe	❑ Dull ❑ Radiating ❑ Sharp ❑ Tingling		❑ Constant ❑ Daily ❑ Intermittent ❑ Occasional
Lower Back Pain	❑ Left ❑ Right	❑ Mild ❑ Moderate ❑ Severe	❑ Dull ❑ Radiating ❑ Sharp ❑ Tingling		❑ Constant ❑ Daily ❑ Intermittent ❑ Occasional
Shoulder Pain	❑ Left ❑ Right	❑ Mild ❑ Moderate ❑ Severe	❑ Dull ❑ Radiating ❑ Sharp ❑ Tingling		❑ Constant ❑ Daily ❑ Intermittent ❑ Occasional
Arm Pain	❑ Left ❑ Right	❑ Mild ❑ Moderate ❑ Severe	❑ Dull ❑ Radiating ❑ Sharp ❑ Tingling		❑ Constant ❑ Daily ❑ Intermittent ❑ Occasional
Elbow Pain	❑ Left ❑ Right	❑ Mild ❑ Moderate ❑ Severe	❑ Dull ❑ Radiating ❑ Sharp ❑ Tingling		❑ Constant ❑ Daily ❑ Intermittent ❑ Occasional
❑ Wrist Pain ❑ Hand Pain	❑ Left ❑ Right	❑ Mild ❑ Moderate ❑ Severe	❑ Dull ❑ Radiating ❑ Sharp ❑ Tingling		❑ Constant ❑ Daily ❑ Intermittent ❑ Occasional
Leg Pain	❑ Left ❑ Right	❑ Mild ❑ Moderate ❑ Severe	❑ Dull ❑ Radiating ❑ Sharp ❑ Tingling		❑ Constant ❑ Daily ❑ Intermittent ❑ Occasional
Hip Pain	❑ Left ❑ Right	❑ Mild ❑ Moderate ❑ Severe	❑ Dull ❑ Radiating ❑ Sharp ❑ Tingling		❑ Constant ❑ Daily ❑ Intermittent ❑ Occasional
Knee Pain	❑ Left ❑ Right	❑ Mild ❑ Moderate ❑ Severe	❑ Dull ❑ Radiating ❑ Sharp ❑ Tingling		❑ Constant ❑ Daily ❑ Intermittent ❑ Occasional
❑ Ankle Pain ❑ Foot Pain	❑ Left ❑ Right	❑ Mild ❑ Moderate ❑ Severe	❑ Dull ❑ Radiating ❑ Sharp ❑ Tingling		❑ Constant ❑ Daily ❑ Intermittent ❑ Occasional

- **Describe how your Injury or Incident occurred or began:** ______________________________

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- **Where have you been and what treatment have you received for your complaint(s)? - (Check all that apply)**

❑ None ❑ Chiropractic ❑ Medication ❑ Spinal Decompression ❑ Injection: ❑ Trigger point ❑ Facet ❑ ESI

❑ Hospital ❑ Physical Therapy ❑ Surgery: Type? ______________ ❑ Testing: ❑ X-Rays ❑ MRI ❑ CT

- **Name and phone number of doctors who have treated you for your current condition:** ______________________________

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Additional Symptoms / Aggravating Factors

Additional Symptoms	Increases Neck Symptoms	Increases Middle Back Symptoms	Increases Lower Back Symptoms
❑ Loss of Consciousness	*Pain or Stiffness with movement:*	*Pain or Stiffness with movement:*	*Pain or Stiffness with movement:*
❑ Dizziness	❑ Forward bending	❑ Forward bending	❑ Forward bending
❑ Nausea	❑ Backward bending	❑ Backward bending	❑ Backward bending
❑ Vomiting	❑ Turning ❑ R ❑ L	❑ Turning ❑ R ❑ L	❑ Turning ❑ R ❑ L
❑ Visual disturbances	❑ Side bending ❑ R ❑ L	❑ Side bending ❑ R ❑ L	❑ Side bending ❑ R ❑ L
❑ Ear(s) ringing	**Headache Description**	**Upper Extremity**	***LBP Pain Worsened with:***
❑ Anxiety / Irritability	❑ Migraine	❑ Numbness ❑ R ❑ L	❑ Sitting ❑ Standing
❑ Nervousness	❑ Forehead	❑ Shooting Pain ❑ R ❑ L	❑ Lifting ❑ Reaching
❑ Fatigue	❑ Back of head	❑ Weakness ❑ R ❑ L	❑ Coughing ❑ Sneezing
❑ Difficulty sleeping	❑ Temples	**Lower Extremity**	**Other Complaints:**
❑ Difficulty concentrating	❑ Behind the eyes	❑ Numbness ❑ R ❑ L	1.
❑ Memory loss	Headache frequency - _____ x / wk.	❑ Shooting Pain ❑ R ❑ L	2.
❑ Difficulty staying focused		❑ Weakness ❑ R ❑ L	3.

BY SIGNING BELOW, I ACKNOWLEDGE THAT THE INFORMATION PROVIDED ABOVE IS BOTH ACCURATE AND COMPLETE

______________________________ ______________

Signature of Patient / Legal Guardian and Relationship to Patient **Date**

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Printed Name of Patient / Legal Guardian

PAST HEALTH HISTORY

Name:

Past Medical History				
❑ Abdominal pain	❑ Cancer / Tumor(s)	❑ Fibromyalgia	❑ Migraine headaches	❑ Stroke
❑ AIDS / HIV	Explain:	❑ Fracture:	❑ Neuropathy	❑ Swelling in limbs
❑ Allergies / Hay fever	❑ Chemotherapy	❑ Frequent Diarrhea	❑ Osteoporosis	❑ Thyroid problems
❑ Anemia	❑ Radiation therapy	❑ Heart disease	❑ Pacemaker	❑ Tobacco use
❑ Anxiety	❑ Chest pain	❑ Hepatitis A, B, C (circle)	❑ Parkinson's disease	❑ Tuberculosis
❑ Arthritis	❑ Constipation	❑ Herniated or bulging disc	❑ Prostate problems	❑ Ulcers
❑ Artificial joint (hip, knee)	❑ Cortisone Medication	❑ High blood pressure	❑ Psychiatric care	❑ Urinary problems
❑ Asthma	❑ Depression	❑ High cholesterol	❑ Sciatica	❑ Weight gain (> 10 lbs.)
❑ Autoimmune problems	❑ Diabetes	❑ Jaw / TMJ Pain	❑ Seizures	❑ Weight loss (> 10 lbs.)
❑ Blood disease	❑ Epilepsy	❑ Kidney disease	❑ Skin rash / lesions	❑ Other:
❑ Bowel/Bladder problem	❑ Emphysema	❑ Latex sensitivity	❑ Spina bifida	
❑ Bronchitis	❑ Fainting spells	❑ Liver disease	❑ Stomach problem(s)	❑ Other:

- **Please list ALL previous surgeries and/or hospitalizations:** ______________________________

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- **Please list ALL medications currently taking:** ______________________________

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- **List any medication allergies or sensitivity:** ______________________________
- **Previous Injuries:**
  - ❑ **Motor Vehicle Collision - Date and any treatment received?** ______________________________
  - ❑ **Workers' Compensation Claim: Please describe / date and treatment:** ______________________________
  - ❑ **Other type – Please describe, date and treatment:** ______________________________

  Have you ever had a serious head or neck injury? ❑ **Yes** ❑ **No** **If yes, explain:** ______________________________

- **Women ONLY: Are you pregnant/trying to get pregnant:** ❑ **Yes** ❑ **No** ❑ **Unsure** **Are you nursing?** ❑ **Yes** ❑ **No**

  Are you taking oral contraceptives? ❑ **Yes** ❑ **No** **Date of last menstrual period:** ______________________________

Current Job Description / Responsibilities					
Work Requirements	**Never**	**Occasional** (0 - 1/3 day)	**Frequent** (1/3 - 2/3 day)	**Constant** (2/3 - full day)	**Please provide a description of your job duties**
Lifting 1-10 pounds	❑	❑	❑	❑	
Lifting 11-20 pounds	❑	❑	❑	❑	
Lifting 21-50 pounds	❑	❑	❑	❑	
Lifting 51-99 pounds	❑	❑	❑	❑	
Lifting >100 pounds	❑	❑	❑	❑	
Sitting	❑	❑	❑	❑	
Standing	❑	❑	❑	❑	
Kneeling/Squatting	❑	❑	❑	❑	
Bending/Stooping	❑	❑	❑	❑	
Pushing/Pulling	❑	❑	❑	❑	
Twisting	❑	❑	❑	❑	
Reaching	❑	❑	❑	❑	

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Signature of Patient / Legal Guardian and Relationship to Patient **Date**

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