



Injury Screen Form

Welcome to our practice!

Please help us serve you better by taking a few minutes to provide the following information

Name:			Today's date:		
	Last Name	First Name			
Address:					
City / State / ZIP:					
Phone #	MOBILE		HOME		WORK
DOB:			Age:		Marital status: M S W D
Email:					
Occupation:			Employer:		
Emergency Contact	Name:		Phone:		
Primary Care Physician	Name:		Date of next visit:		
Specialist Physician	Name:		Date of next visit:		

How did you hear about our practice?	
Who can we thank for referring you to our practice?	

What is the primary issue/problem that brings you in today?	<p>Please X in areas where you have pain, discomfort, or tension.</p>
Secondary concern/problem?	
As a result, I am now having difficulty with:	
Are you currently experiencing pain as a result of these symptoms? If yes, what is it like?	
When did your symptom(s) begin? (Date):	

Please rate your pain in the last 24-72 hours Using the "0 -10" scale where 0 is no pain and 10 is the worst possible pain.		Level	Description
	At its worst		
	At its best		
	At present		
	Night		



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At what time of day are your symptoms the worst?	
At what time of day are your symptoms the best?	
What activities increase your pain?	
What activities decrease your pain?	

What other types of treatment have you had for this problem?											
<input type="checkbox"/>	Massage	<input type="checkbox"/>	Bodywork	<input type="checkbox"/>	Physical Therapy	<input type="checkbox"/>	Myofascial Release	<input type="checkbox"/>	Chiropractic	<input type="checkbox"/>	Surgery
Other Medical Treatment: (please describe)											

Check the box if you have had any of the following medical conditions?											
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Lung disease	<input type="checkbox"/>	Weight change	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	Neurologic Problems	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	Epilepsy / seizures	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Blackouts
<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Malignancy	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Broken bones (fractures)	<input type="checkbox"/>	Metal implants	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	Circulatory problems	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	Heart disease / pacemaker	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	Others (explain below)		

List past medical history and dates of occurrence. Include surgeries, accidents and other traumas.

List ALL medications which you are currently taking, the condition for which you are using them, the dose, and their effectiveness. (Include supplements, herbal and homeopathic remedies).			
Medication	For treatment of	Dose / Amount per day	Effectiveness



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Do you smoke?	Yes	No	If "Yes" – How much?	
When did you quit?			If not, Would you like to quit?	

Is there a chance you may be pregnant at this time?	Yes	No
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Do you engage in regular exercise?	Yes	No
What type and how often?		
Are you able to exercise now?	Yes	No

Do you have discomfort, shortness of breath, or pain with exercise?	Yes	No			
Please Describe:					
In general, your lifestyle is:	1	2	3	4	5
	Active		Average		Inactive

If sleep is a problem, answer these questions:

Do you have trouble falling asleep?	Yes	No	Do you find it difficult to change positions in bed?	
Is your sleep restful?	Yes	No	How many times do you wake in the night?	
Do you find it difficult to lie down?	Yes	No	How long before you fall back to sleep?	

List all the Tasks / Activities that you have difficulty performing and your tolerance

Task / Activity	Tolerance (minutes/hours)

Patient Goals

Task / Activity	Duration / How Often	By When
Other Goals?		