CHIROPRACTIC CENTER OF NEW BRITAIN **Francis J. Vesci, D.C.**

NEW PATIENT HISTORY FORM (Personal Injury)

Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.

Symptom 1_____

Ona scale from 0-10, with 10 being the worst, please circle the number that best describes your symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin? _____

- Was the symptom the result of a motor vehicle collision? Yes No (circle one)
- **Did you have this symptom before the motor vehicle collision?** Yes No (circle one)
  - If so, what was the intensity (0-10 w/ 10 being worst) and frequency (0-100%) _____

What makes the symptom worse? (circle all that apply):

- Bending neck forward, bending neck backward, tilting head left, tilting head right, turning head left, turning head right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting, lifting, any movement, driving, walking, running, nothing, other (please describe):_____

What makes the symptom better? (circle all that apply):

- Rest, ice, heat, stretching, exercise, massage, muscle relaxers, nothing
  Other (please describe): _____

Describe the quality of the symptom (circle all that apply):

- Sharp, dull, achy, burning throbbing, piercing, stabbing deep nagging, shocking, stinging,
  Other (please describe): _____

Does the symptom radiate to another part of your body? (circle one): Yes No

- If Yes, where does the symptom radiate: _____

Is the symptom worse at certain times of the day or night? (circle one):

- Morning Afternoon Evening Night Unaffected by time of day

Symptom 2_____

Ona scale from 0-10, with 10 being the worst, please circle the number that best describes your symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin? _____

- Was the symptom the result of a motor vehicle collision? Yes No (circle one)
- **Did you have this symptom before the motor vehicle collision?** Yes No (circle one)
  - If so, what was the intensity (0-10 w/ 10 being worst) and frequency (0-100%) _____

(Continued on back)

What makes the symptom worse? (circle all that apply):

- Bending neck forward, bending neck backward, tilting head left, tilting head right, turning head left, turning head right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting, lifting, any movement, driving, walking, running, nothing, other (please describe):_____

What makes the symptom better? (circle all that apply):

- Rest, ice, heat, stretching, exercise, massage, muscle relaxers, nothing
  Other (please describe): _____

Describe the quality of the symptom (circle all that apply):

- Sharp, dull, achy, burning throbbing, piercing, stabbing deep nagging, shocking, stinging,
  Other (please describe): _____

Does the symptom radiate to another part of your body? (circle one): Yes No

- If Yes, where does the symptom radiate: _____

Is the symptom worse at certain times of the day or night? (circle one):

- Morning Afternoon Evening Night Unaffected by time of day

Symptom 3_____

Ona scale from 0-10, with 10 being the worst, please circle the number that best describes your symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin? _____

- Was the symptom the result of a motor vehicle collision? Yes No (circle one)
- **Did you have this symptom before the motor vehicle collision?** Yes No (circle one)
  - If so, what was the intensity (0-10 w/ 10 being worst) and frequency (0-100%) _____

What makes the symptom worse? (circle all that apply):

- Bending neck forward, bending neck backward, tilting head left, tilting head right, turning head left, turning head right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting, lifting, any movement, driving, walking, running, nothing, other (please describe):_____

What makes the symptom better? (circle all that apply):

- Rest, ice, heat, stretching, exercise, massage, muscle relaxers, nothing
  Other (please describe): _____

Describe the quality of the symptom (circle all that apply):

- Sharp, dull, achy, burning throbbing, piercing, stabbing deep nagging, shocking, stinging,
  Other (please describe): _____

Does the symptom radiate to another part of your body? (circle one): Yes No

- If Yes, where does the symptom radiate: _____

(Continued on Back)

Is the symptom worse at certain times of the day or night? (circle one):

- Morning Afternoon Evening Night Unaffected by time of day

Symptom 4_____

Ona scale from 0-10, with 10 being the worst, please circle the number that best describes your symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin? _____

- Was the symptom the result of a motor vehicle collision? Yes No (circle one)
- **Did you have this symptom before the motor vehicle collision?** Yes No (circle one)
  - If so, what was the intensity (0-10 w/ 10 being worst) and frequency (0-100%) _____

What makes the symptom worse? (circle all that apply):

- Bending neck forward, bending neck backward, tilting head left, tilting head right, turning head left, turning head right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting, lifting, any movement, driving, walking, running, nothing, other (please describe):_____

What makes the symptom better? (circle all that apply):

- Rest, ice, heat, stretching, exercise, massage, muscle relaxers, nothing
  Other (please describe): _____

Describe the quality of the symptom (circle all that apply):

- Sharp, dull, achy, burning throbbing, piercing, stabbing deep nagging, shocking, stinging,
  Other (please describe): _____

Does the symptom radiate to another part of your body? (circle one): Yes No

- If Yes, where does the symptom radiate: _____

Is the symptom worse at certain times of the day or night? (circle one):

- Morning Afternoon Evening Night Unaffected by time of day

Symptom 5_____

Ona scale from 0-10, with 10 being the worst, please circle the number that best describes your symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

(Continued on Back)

When did the symptom begin? _____

- Was the symptom the result of a motor vehicle collision? Yes No (circle one)
- **Did you have this symptom before the motor vehicle collision?** Yes No (circle one)
  - If so, what was the intensity (0-10 w/ 10 being worst) and frequency (0-100%) _____

What makes the symptom worse? (circle all that apply):

- Bending neck forward, bending neck backward, tilting head left, tilting head right, turning head left, turning head right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting, lifting, any movement, driving, walking, running, nothing, other (please describe):_____

What makes the symptom better? (circle all that apply):

- Rest, ice, heat, stretching, exercise, massage, muscle relaxers, nothing
  Other (please describe): _____

Describe the quality of the symptom (circle all that apply):

- Sharp, dull, achy, burning throbbing, piercing, stabbing deep nagging, shocking, stinging,
  Other (please describe): _____

Does the symptom radiate to another part of your body? (circle one): Yes No

- If Yes, where does the symptom radiate: _____

Is the symptom worse at certain times of the day or night? (circle one):

- Morning Afternoon Evening Night Unaffected by time of day

Symptom 6_____

Ona scale from 0-10, with 10 being the worst, please circle the number that best describes your symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin? _____

- Did the symptom begin suddenly or gradually ? (circle one)
- How did the symptom begin? _____

What makes the symptom worse? (circle all that apply):

- Bending neck forward, bending neck backward, tilting head left, tilting head right, turning head left, turning head right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting, lifting, any movement, driving, walking, running, nothing, other (please describe):_____

What makes the symptom better? (circle all that apply):

- Rest, ice, heat, stretching, exercise, massage, muscle relaxers, nothing
  Other (please describe): _____

(Continued on Back)

Describe the quality of the symptom (circle all that apply):

- Sharp, dull, achy, burning throbbing, piercing, stabbing deep nagging, shocking, stinging,
  Other (please describe): _____

Does the symptom radiate to another part of your body? (circle one): Yes No

- If Yes, where does the symptom radiate: _____

Is the symptom worse at certain times of the day or night? (circle one):

- Morning Afternoon Evening Night Unaffected by time of day