

PERSONAL HISTORY

What is the most you ever weighed? _____ When? _____

Do you smoke? YES NO How much do you smoke? _____ packs/day _____ packs/week
How long have you been a smoker? _____ Have you been a smoker in the past? YES NO
How long have you stopped smoking? _____

Do you drink alcoholic beverages? YES NO
How much do you drink? _____ drinks/day _____ drinks/week _____ drinks/month
How long have you been drinking alcoholic beverages? _____ months _____ years

How many children did you give birth to? _____ What are their ages? _____

Do you commute to work? YES NO if yes, how long is the commute? _____
What means of transportation? (Ex. Bus, drive car, carpool, walk, etc...) _____

Do you presently exercise on a regular basis? YES NO If yes, complete below:

Activity	Duration	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

List exercise activity prior to your problem:

Activity	Duration	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any known food allergies? _____

What did you eat and drink yesterday:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you crave certain foods: _____

Does any food you eat cause any discomfort: _____

8oz. Glasses per day

Water/day = _____ Soda/day = _____ Tea/day = _____ Other: _____

Your last bowel movement was: _____

How often do you have a bowel movement: 1x/day 2x/day 3x/day Other: _____

PERSONAL HISTORY

Do you have, or have had, any of the following?

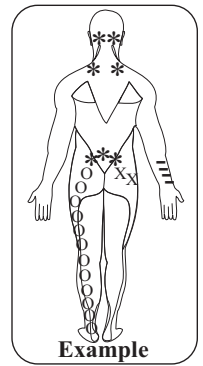
Problem	NO	YES	When	What
Surgery				
Surgery				
Surgery				
Cancer				
Broken Bone				
Broken Bone				
Scoliosis				
Heart Problems				
High Blood Pressure				
Stroke				
Diabetes				
Rheumatic Fever				
Rheumatoid Arthritis				
Gout				
Lupus				
Psoriasis				
Multiple Sclerosis				
Lung Problems				
Other				
Other				
Other				

FAMILY HISTORY

Do any of your BLOOD FAMILY have, or have had, any of the following?

Problem	NO	YES	When	What
Chronic Back Pain				
Chronic Neck Pain				
Spine Surgery				
Cancer				
Heart Problems				
High Blood Pressure				
Stroke				
Diabetes				
Rheumatic Fever				
Rheumatoid Arthritis				
Gout				
Lupus				
Psoriasis				
Multiple Sclerosis				
Lung Problems				
Scoliosis				
Other				
Other				
Other				
Other				
Other				

PAIN CHART



Date: _____

Signature: _____

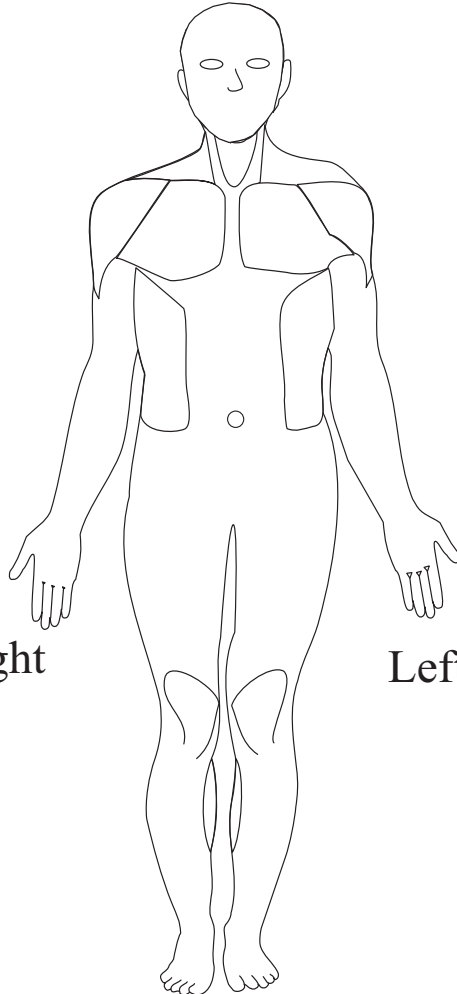
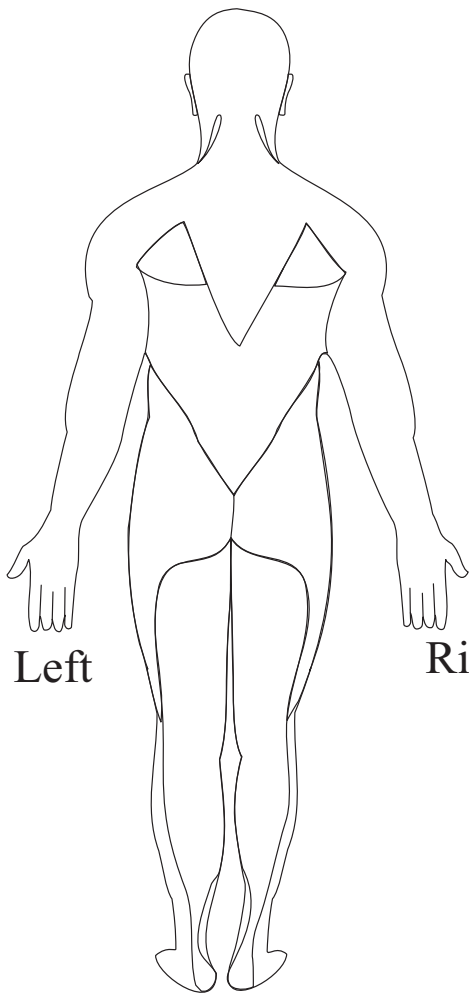
SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations.

Use the appropriate symbols (See box below)

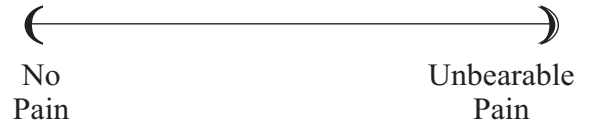
Mark areas of radiation (Ex. down leg, down arm, into hip, etc.) Include all affected areas.

Numbness -----	Pins & Needles OOOOO	Burning XXXXX	Aching *****	Cramping CCCCC	Stabbing /////
--------------------------	------------------------------------	-------------------------	------------------------	--------------------------	--------------------------



Neck-Shoulder-Arm-Pain

I rate my discomfort as follows:



Mid Back Pain

I rate my discomfort as follows:



Low Back and Leg Pain

I rate my discomfort as follows:



Best You Have Felt This Week **Worst Pain This Week**

← No Pain Unbearable Pain No Pain Unbearable Pain →

Average Pain This Week

← No Pain Unbearable Pain →

Please complete back side of this page

Symptom Questionnaire

What is your Chief/Primary Complaint? _____

How did this condition develop? _____

Overexertion / Strenuous Position / Auto Accident / Work Accident / Fall / Trauma

ONSET: When was the first time (date) you were aware of the problem? _____

PROV: What makes the problem worse? _____
Coughing/Sneezing / Lifting / Bending / Prolonged Sitting / Driving / Standing / Walking

PALL: What relieves the problem? _____
Rest / Movement/Exercise / Sitting / Standing / Lying / Ice / Heat / Drugs-Aspirin / Tylenol /
Ibuprofen / Drugs-Other: _____

QUALITY: How would you describe the pain or problem? _____
Sharp / Stabbing / Dull / Aching / Burning / Throbbing / Pins & Needles / Numbness

RADIATES: Does this refer into another part of your body? Left Side of / Right Side of
Head / Neck / Shoulder / Arm / Hand / Back / Hip / Leg & Thigh / Calf / Foot _____

TIME: Is there any certain time of day that you notice the pain being worse?

Morning / Afternoon / Evening / Bedtime / Wakes me up at night / At Work / After Work

How long does the pain/problem last? _____
Brief / Intermittent / Occasional / Frequent / Constant

Have you ever had the same or similar problem before? YES NO If yes, when?
Please explain: _____

Have you seen another doctor for this problem before? NO (YES Dr. _____)
Recommendations or prescriptions? _____
Please list any other medication you are currently taking. _____

Please list any vitamin or herbal supplements you are currently taking. _____

Have you ever been treated by a chiropractor before? NO (YES Dr. _____)
Did the chiropractor adjust your Neck (Y / N), Mid Back (Y / N), Low Back (Y / N)? _____

Please list any significant accidents (automobile or other) or falls? _____



AUTO ACCIDENT INFORMATION

"Dedicated to helping you live a healthy, productive and long life"

DR. RICHARD M. NOVAK
 Certified in Spinal Trauma

Patient Name: _____ Date: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 S.S.#: _____ Date of Birth: _____ Age: _____ Sex: M F
 Marital Status: S/M/D/W Children: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 Occupation: _____
 Employer's Name and Address: _____
 Name of relative not living with you: _____
 Relationship: _____ Phone #: _____

Name and address of YOUR Auto Insurance Company: (Even if you were not at fault)

Name of **YOUR** insurance carrier: _____
 Address: _____ Phone: _____
 Your auto insurance agent name: _____ Phone: _____
 Address: _____

YOUR attorney's name: _____ Phone: _____
 Address: _____

Name, address, and phone # of the **OTHER** driver involved in accident in **OTHER** vehicle.

Name: _____ Address: _____ Phone: _____

Who was at fault in this accident: **MYSELF** **OTHER DRIVER** **DON'T KNOW**

THEIR automobile insurance company:

Name: _____ Date: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Policy #: _____ Claim #: _____
 Miscellaneous information: _____

Signed: _____ **Today's Date:** _____

GUARANTOR OF PAYMENT



AUTO ACCIDENT HISTORY FORM

"Dedicated to helping you live a healthy, productive and long life"

DR. RICHARD M. NOVAK
 Certified in Spinal Trauma

Your Name: _____ Date: _____
 Date of Accident: _____ Time of Accident: _____ am/pm
 City of Accident: _____ Street of Accident: _____

Road conditions at the time of accident: **WET DRY ICY OTHER:** _____
 Did the police come to the accident scene? **YES NO** Is there a police report? **YES NO**

Did you go to the hospital? **YES NO**
 If yes, what is the name and city of the hospital? _____
 How did you get to the hospital? _____
 What parts of your body were x-rayed at the hospital? _____
 What did the hospital do for your injuries? _____
 How long did you stay at the hospital? _____
 Have you seen any other doctor for this accident? **YES NO**
 If yes, what is the doctor's name? _____

What bleeding cuts did you sustain due to this accident? _____
 What bruises did you sustain due to this accident? _____
 Where were you seated in the vehicle? _____
 Were you aware of the approaching collision prior to impact, or did impact catch you by surprise? **AWARE SURPRISE**
 Did you lose consciousness (black out) upon impact? **YES NO**

Did you become: **CONFUSED DISORIENTED LIGHT HEADED**
DIZZY NAUSEATED BLURRED VISION RING/BUZZ IN EARS
 From accident? (Please circle)
 If you still have any of those symptoms, which ones? _____

Are you currently suffering from any of the following (please circle):
RESTLESSNESS IRRITABLE
DIFFICULT CONCENTRATING DIFFICULT WITH MEMORY
SLEEPLESSNESS FORGETFULNESS
REDUCED TOLERANCE TO HEAT REDUCED TOLERANCE TO ALCOHOL

How far was the top of the headrest or seatback from the top of your head (approximately):
 _____ inches **ABOVE or BELOW**
 Were you wearing your seatbelt? **YES NO**
 If yes, was it a lap seatbelt _____ shoulder-lap seatbelt _____

Please list, make and model of the vehicle you were in:

Year _____ Make _____ Model _____

Was your car stopped at the time of impact? **YES NO**

If yes, was the driver's foot also on the brake? **YES NO**

If no, then estimate the speed of the vehicle you were in: _____ mph

If your vehicle was moving at the time of impact, was it:

Slowing down? **YES NO** Gaining speed? **YES NO**

Traveling at a steady rate of speed? **YES NO**

On what part of the automobile did your following body parts hit?

Head hit _____ Chest hit _____

Right/left shoulder hit _____ Right/left arm hit _____

Right/left hip hit _____ Right/left leg hit _____

Right/left knee hit _____ Other _____

Did you receive any injury or bruise from the seat belt? **YES NO**

If yes, then describe: _____

Did you receive any injury or bruise from the air bag? **YES NO**

If yes, then describe: _____

Which of the following car parts broke during the accident? (Please circle)

Windshield _____ Front seat back _____

Right/left side window _____ Other _____

Steering wheel _____ Other _____

Was the trunk of your body pointed straight forward at the time of the collision?

YES NO If no, how was it turned? _____

Was your head pointed straight forward? **YES NO** If no, what direction was it turned

and by how much? _____

What is the year, make and model of the **other** vehicle?

Year _____ Make _____ Model _____

Was the other vehicle moving at the time of the collision? **YES NO**

If yes, what was its approximate speed? _____ mph

If the other vehicle was moving at the time of the collision, was it (please circle):

SLOWING DOWN GAINING SPEED TRAVELING AT A STEADY SPEED

Please describe, to the best of your knowledge, what happened during this accident:

Signed: _____ **Today's date:** _____