Questionnaire

please answer all questions completely

Dear patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name _____ Sex_____ Marital Status _____ DOB _____

Home Phone_____ Address _____ City_____ State _____

Zip_____ Occupation_____

Social Security # _____ Business Phone _____ Company Name _____

Spouse's First Name_____ Spouse's Soc, Sec, # _____ Spouse's Employer _____

Please explain in detail how your accident happened _____

_____

_____

_____

What were the time and date of present injury?_____
Where did you feel pain immediately after the accident?_____
List the extent of your injuries as you know them:_____

_____

_____

Did you require post accident hospitalization? Yes No

Circlo symptoms you have noticed since the accident:

Headache	Dizziness	Depression	Fatigue
Stomach Upset	Light Bothers Eyes	Buzzing in Ears	Diarrhea
Neck Pain	Head Seems Too Heavy	Loss of Memory	Feet Cold
Neck Stiff	Pins & Needles in Arms	Ears Ring	Hands Cold
Fainting	Sleeping Problems	Loss of Balance	Back Pain
Face Flushed	Pins & Needles in Legs	Constipation	Tension
Nervousness	Numbness in Fingers	Loss of Smell	Fever
Irritability	Numbness in Toes	Loss of taste	Chest Pain
Cold Sweats	Shortness of Breath	_____	_____

Symptoms other than above:_____

_____

Where were you taken after the accident?_____
Hospitalized? Yes No If yes, admitted? _____ **How Long?** _____
Name of Hospital _____
Name of doctors _____
What treatment was given? _____
Was any other doctor consulted after your accident? ◯Yes ◯No
If so, what was the doctor's name? _____ **D.C., M.D., D.O., D.D.S**
What was the diagnosis? _____

JAMAICA CHIROPRACTIC &
PHYSICAL THERAPY PLLC
144-31 JAMAICA AVENUE
JAMAICA, NY 11435

Functional capacity checklist.

Please indicate your degree of pain while performing the following activities on a scale of 0 (No pain) to 10 (severe pain) or **N.Y.P.** (Not yet performed)

Sleeping	
Lying on black	
Lying on side	
Lying on stomach	
Sitting	
Standing	
Bending	
Lifting	
Kneeling	
Pulling	
Pushing	
Twisting	
Crawling	
Going up/down stairs	
Carrying	
Dressing/undressing	
Showering/bathing	
Putting shoes/socks/bra/shirt/pants on/off	
Cooking	
Food shopping	
Laundry	
Sweeping	
Typing	
Walking	
Running	
Sports	
Exercising	
Intimate relations	
Other	
Other	
Other	

Signature _____

Date _____

Balance Self Test

Are You At Risk For Falls?

Patient Name: _____ SSN: _____

1. Have you fallen more than once in the past year? ◯ YES ◯ NO

2. Do you lose balance when standing still, or
   When you initially get up after sitting? ◯ YES ◯ NO

3. Does it take you more than one try to get out of a chair or out of bed? ◯ YES ◯ NO

4. Do you lose your balance or feel unsteady when walking? ◯ YES ◯ NO

5. Do you get dizzy, faint or have seizures? ◯ YES ◯ NO

6. Do you trip over your own feet or objects on the floor? ◯ YES ◯ NO

7. Do you take corners too sharp and bump into corners or door frames? ◯ YES ◯ NO

8. Do you use a walker, cane or need assistance to get around? ◯ YES ◯ NO

9. Have you had a recent loss or decrease in, vision or hearing? ◯ YES ◯ NO

10. Do you have numbness or loss of sensation in your feet or your legs? ◯ YES ◯ NO

11. Have you experienced a stroke or any other health problems
that may have affected your balance? ◯ YES ◯ NO

If you answered YES to one or more questions, you may have a balance problem. If you are concerned about falling, or simply want to take a balance test please speak to your physician.

NCV/SSR self Test

Patient Name: _____

1. Do you suffer from neck pain, with pain in your arms and legs? YES ◯ NO ◯
2. Do you have weakness, numbness, or burning in either your arms or your hands? YES ◯ NO ◯
3. Do your hands or arms fall asleep? YES ◯ NO ◯
4. Do you have reduced feeling (sensation) in your hands or arms? YES ◯ NO ◯
5. Do you suffer from loss of hand grip strength? YES ◯ NO ◯
6. Do you suffer from back pain with pain in your buttocks, legs, or feet YES ◯ NO ◯
7. Do you have weakness, numbness, or burning in your buttocks, legs, or feet? YES ◯ NO ◯
8. Do your legs or feet fall asleep? YES ◯ NO ◯
9. Do you have reduced feeling (sensation) in your buttocks, legs, or feet? YES ◯ NO ◯
10. Do you have a pacemaker? YES ◯ NO ◯

If you answered YES then you are **not allowed** to take this test!!

If you answered YES to one or more questions, please speak with your physician about having this test preformed.

JAMAICA CHIROPRACTIC & PHYSICAL THERAPY, PLLC. 144-31
JAMAICA AVE. JAMAICA, NY 11435
P: 718-206-3369
F: 855-201-6872
Jcptl 4431@gmail.com
Jamaicalnjurydoc@gmail.com

Thank you for taking your time and filling out this questionnaire about your prior health history including events not related to this accident. The more we know about you the better we will be able to serve you. Filling this questionnaire out completely will save you approximately I hour of your time in our office. Dr. Long

How did your accident happen?

_____

_____

_____

Previous treatment for this accident (Please circle):

1. Hospital/ family doctor/ therapy facility/ Other
Date:
Name of facility:

2. Hospital/ family doctor/ therapy facility/ Other
Date:
Name of facility:

3. Hospital/ family doctor/ therapy facility/ Other
Date:
Name of facility:

Please list any x-rays, CT scans, MRIs that were performed and to what body part. Also list the which facility which performed them.

_____

_____

Please list any medications which were given to you, prescribed to you recommended for you as a result of this accident. Please list the medication name, who prescribed it and what you are taking it for:

_____

_____

Please list any procedures or injections which were performed for this current accident and which facility listed performed then.

_____

_____

Please advise if you have lost any time from work as a direct result of your injuries from this accident.

- ◯ Yes
- ◯ No

At work as a direct result of your injuries:

- ◯ I am unable to perform all of my tasks at work
- ◯ I am able to perform all of my tasks at work

Please list all of your prior:

Motor vehicle accidents NOT related to this accident. (year, body parts injured, approximately date of last treatment and if resolved)

1.

2.

3.

Work accidents NOT related to this accident. (Year, body parts injured, approximately date of last treatment and if resolved)

1.

2.

3.

Surgeries related to this accident (please list year, body part, approximate date of last treatment and if resolved)

1.

2.

Prior surgeries NOT related to this accident (please list year, body part and if resolved)

1.
2.
3.
4.
5.

Please list any past history of any major medical condition you currently have or have been previously diagnosed with in the past (Include past heart, lung, kidney, liver G.I, high blood pressure, high cholesterol, stroke, vascular or neurological conditions) Please list year diagnosed and condition.

1.
2.
3.
4.
5.

Medications you are currently taking as a direct result of this accident. Please list medication name, who prescribed it and what you were taking it for. (also include any non-prescription medication)

1.
2.
3.
4.
5.

Medications you are currently taking NOT because of this accident. Please advise what condition you are taking this medication for.

1.
2.
3.
4.
5.