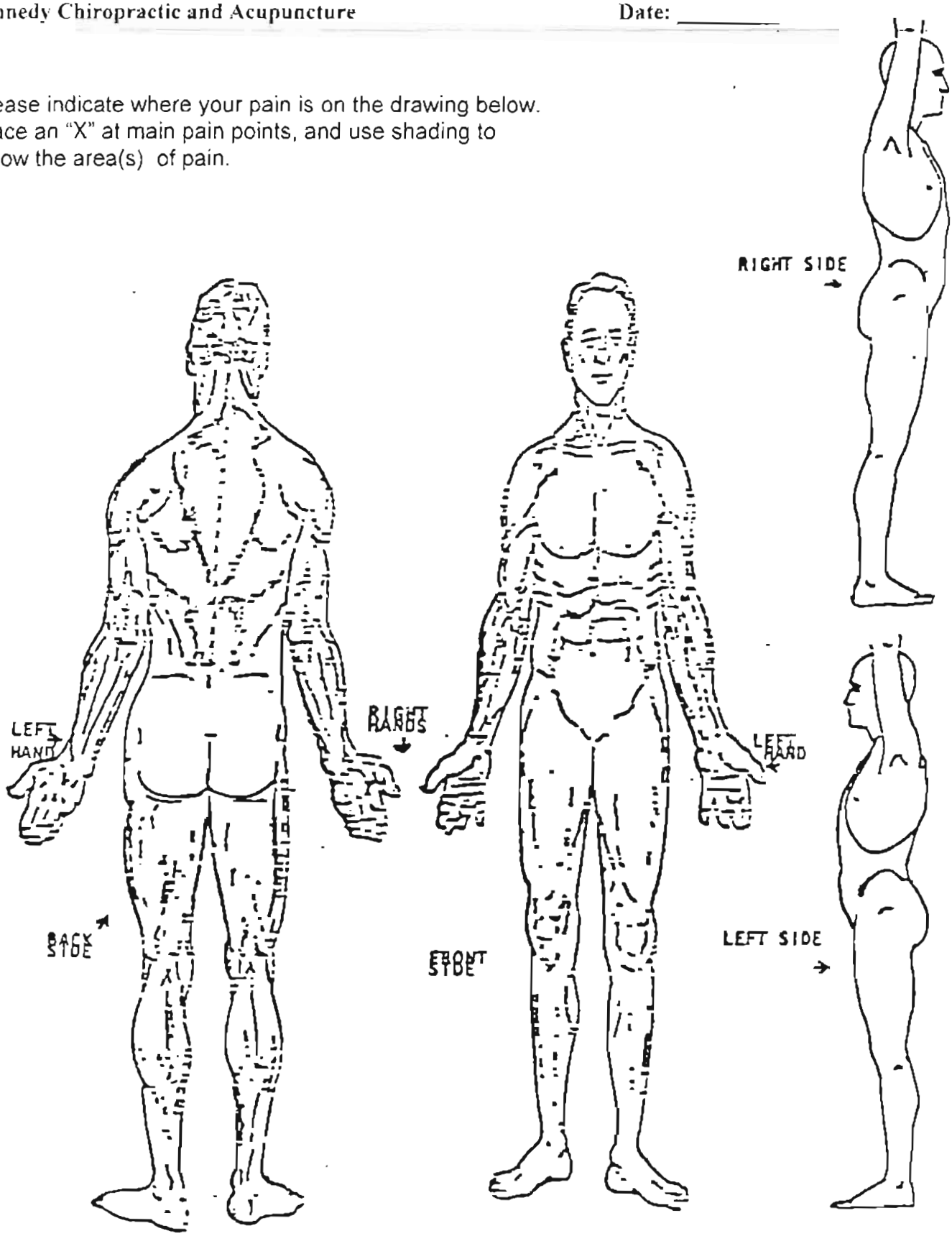
Kennedy Chiropractic and Acupuncture Date: _____

-Please indicate where your pain is on the drawing below.
-Place an "X" at main pain points, and use shading to show the area(s) of pain.



Signature:_____ Date:_____

Kennedy Chiropractic and Acupuncture
3405 Penrose Place, Suite 106
Boulder, Colorado 80301
303-546-6325
www.ColoPainClinic.com

IDENTIFICATION / INTRODUCTION

1. Name: _____ Age: _____
2. Hand dominance: ☐ Right ☐ Left ☐ Both
3. Ethnic Group: ☐ White ☐ Black ☐ Hispanic ☐ American Indian ☐ Asian ☐ Other
4. Gender: ☐ Male ☐ Female

5. Are you receiving any sort of disability income? ☐ yes ☐ no

If yes, what is the source:	Amount
☐ Workers Compensation Insurance	_____
☐ Automobile insurance	_____
☐ Personal disability insurance	_____
☐ Pension fund	_____
☐ Social Security Disability income	_____
☐ Other	_____

INJURY OR ACCIDENT

(The purpose of this section is to understand how you became injured or ill.)

6. Date of Accident: _____
   ☐ My illness came on gradual but started about _____

7. Automobile Accident

[Skip the following questions if you were not in an automobile accident. The following questions are for this claim only (one accident only).]

a. Time of accident: _____

b. Road Conditions at time of accident: ☐ wet ☐ dry ☐ icy ☐ dirt

c. You were ☐ driver ☐ passenger front ☐ passenger rear ☐ pedestrian

d. Were you wearing a seat belt? ☐ yes ☐ no

e. Type of cars: yours _____ theirs _____

f. Your car was going (direction) _____ on _____ street _____.

g. Your car was ☐ moving ☐ stopped ☐ turning

h. Your car was ☐ struck by another vehicle ☐ struck another vehicle ☐ struck a stationary object ☐ other

i. Your car was hit ☐ front ☐ rear ☐ right side ☐ left side ☐ right front ☐ left front ☐ right rear ☐ left rear

j. The other vehicle was hit ☐ front ☐ rear ☐ right side ☐ left side ☐ right front ☐ left front ☐ right rear ☐ left rear

k. Your speed: ____ miles per hour. The other vehicles speed: ____ miles per hour.

l. Did you see the accident coming? ☐ yes ☐ no

m. Upon impact: ☐ tensed body for impact ☐ neck whipped back and forward ☐ thrown over seat ☐ thrown to side ☐ thrown from vehicle ☐ pinned in vehicle

n. Did your body cause internal damage to your car? ☐ yes ☐ no

o. Did your body hit any part of your car? ☐ yes ☐ no

p. Were you unconscious? ☐ yes ☐ no How long? _____

q. Were you attended to by paramedics? ☐ yes ☐ no

r. Ambulence to hospital? ☐ yes ☐ no

s. Where did you go immediately after the accident?

☐ hospital ☐ home ☐ personal doctor ☐ this office ☐ resumed activities

t. Was a police report made? ☐ yes ☐ no

8. Describe work accident or how your illness or pain began.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

9. Immediate effects after the accident:

_____

_____

10. Gradual or delayed effects:

_____

_____

CURRENTLY (Subjective)

(The following questions are about how your illness is effecting you now.)

11. PAIN DRAWING (Attached)

12. List your pain and problems in order of severity (most severe first):

a. _____

b. _____

c. _____

d. _____

e. _____

13. The following items listed may increase, decrease or have no effect on your pain. Please mark the one that applies to you best. Leave blank if no effect.

	Increases	Decreases
Movement	☐	☐
Walking	☐	☐
Bending	☐	☐
Lifting	☐	☐
Reaching	☐	☐
Grasping	☐	☐
Twisting	☐	☐
Distraction (TV, Movie, Reading)	☐	☐
Urination, Bowel Movements	☐	☐
Stress/Tension	☐	☐
Going to Work	☐	☐
Everything	☐	☐

Is there anything else that increases your pain? _____

Is there anything else that relieves your pain? _____

14. Since the injury your symptoms are: ☐ better ☐ worse ☐ unchanged

15. At this time are your symptoms are: ☐ better ☐ improving ☐ getting worse ☐ unchanged

16. The following words represent degrees of pain severity.

0	none	5-6	distressing (fairly severe)
1-2	mild	7-8	very severe (horrible)
3-4	uncomfortable	9-10	unbearable (excruciating)

Write the number of the words from the above list that describes:

_____ 1. Your pain as it usual feels
_____ 2. Your pain as it is right now.
_____ 3. Your pain at its worst.
_____ 4. Your pain when it hurts the least.

17. How many days a week do you experience pain? ☐ daily ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ intermittent

PRE-EXISTING STATUS

(The purpose of this section is to understand how you were prior to your injury or illness.)

18. Did you have any similar or previous problems? ☐ yes ☐ no

19. Were you under a physician's care or in therapy prior to the injury? ☐ yes ☐ no

20. Have you had any other significant disabling problems or accidents? ☐ yes ☐ no

MEDICAL CARE

(The following questions are about the health care you have received for this illness.)

21. When did you first obtain medical attention? Date ______________
    Place ______________ Doctor ______________

22. Please check all the providers you have seen during this illness.
    Below list their name and service.

Name	Specialty	Date	Role: Treating Physician	Role: Consultant Only	Role: IME	Role: Currently seeing
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐

23. DIAGNOSTIC TESTS *(Please list all diagnostic tests you've had during this illness. Please give dates of those tests you've had and location.)*
(x-ray, MRI, lab, CAT scan, bone scan, neuropsych testing, psychological consultation, visual testing, auditory (ear) testing, dental evaluation, functional capacity assessment, thermogram)

Test	Body Part	Date	Location	Results	Concur?
				☐ WNL ☐ ? ☐ Abn.	☐ Y ☐ N
				☐ WNL ☐ ? ☐ Abn.	☐ Y ☐ N
				☐ WNL ☐ ? ☐ Abn.	☐ Y ☐ N
				☐ WNL ☐ ? ☐ Abn.	☐ Y ☐ N
				☐ WNL ☐ ? ☐ Abn.	☐ Y ☐ N
				☐ WNL ☐ ? ☐ Abn.	☐ Y ☐ N
				☐ WNL ☐ ? ☐ Abn.	☐ Y ☐ N
				☐ WNL ☐ ? ☐ Abn.	☐ Y ☐ N

24. TREATMENTS RECEIVED

Have taken the following:	Yes	Makes Better	Makes Worse	No Effect	Currently
Pain killers	☐	☐	☐	☐	☐
Muscle relaxants	☐	☐	☐	☐	☐
Aspirin	☐	☐	☐	☐	☐
Tylenol (acetominophen)	☐	☐	☐	☐	☐
nonsteroidal anti-inflammatories	☐	☐	☐	☐	☐
steriods	☐	☐	☐	☐	☐
sleeping pills	☐	☐	☐	☐	☐
anti-depressants	☐	☐	☐	☐	☐
pills for your nerves	☐	☐	☐	☐	☐

	Yes	Makes Better	Makes Worse	No Effect	Currently
Ice	☐	☐	☐	☐	☐
Heat	☐	☐	☐	☐	☐
Physical therapy	☐	☐	☐	☐	☐
Strength and conditioning therapy	☐	☐	☐	☐	☐
Work Hardening Program	☐	☐	☐	☐	☐
Pool therapy	☐	☐	☐	☐	☐
Massage therapy	☐	☐	☐	☐	☐
Vision therapy	☐	☐	☐	☐	☐
Myotherapy	☐	☐	☐	☐	☐
Chiropractic manipulation	☐	☐	☐	☐	☐
Osteopathic manipulation	☐	☐	☐	☐	☐
Exercise (during)	☐	☐	☐	☐	☐
Exercise (after)	☐	☐	☐	☐	☐
Tens unit	☐	☐	☐	☐	☐
Ionophoresis	☐	☐	☐	☐	☐
Hot tub	☐	☐	☐	☐	☐
Injections of pain killers	☐	☐	☐	☐	☐
Injections of joints	☐	☐	☐	☐	☐
Injections of tendons	☐	☐	☐	☐	☐
Injections of trigger points	☐	☐	☐	☐	☐
Facet injections	☐	☐	☐	☐	☐
Epidural injections	☐	☐	☐	☐	☐
Stellate ganglion block injections	☐	☐	☐	☐	☐
Brytillium block injections	☐	☐	☐	☐	☐
Guanethidine block injection	☐	☐	☐	☐	☐
Sauna	☐	☐	☐	☐	☐
Back brace	☐	☐	☐	☐	☐
Splints or braces	☐	☐	☐	☐	☐
SI joint brace	☐	☐	☐	☐	☐
Orthotics (Foot cushions)	☐	☐	☐	☐	☐
TMJ splint	☐	☐	☐	☐	☐
Carpal tunnel operation	☐	☐	☐	☐	☐
Disc operation of the neck	☐	☐	☐	☐	☐
Disc operation of the low back	☐	☐	☐	☐	☐
Spine fusion operation of the neck	☐	☐	☐	☐	☐
Spine fusion operation of low back	☐	☐	☐	☐	☐
Arthroscopic operation of shoulder	☐	☐			
Other _____					

25. Are there any remaining problems associated with the procedures performed?

WORK HISTORY

(The purpose of this section is to understand how illness has effected your work and all about your past work experience and skills.)

A. The following questions refer to your employment at the time of your injury:

26. Employed by: _____

27. Job title: _____

28. Date hired: _____

29. Job description: _____

_____

30. Salary: _____

31. Have you tried to return to work? ☐ yes ☐ no

32. If your pain/injury was resolved would you return to this job? ☐ yes ☐ no
☐ part-time ☐ full-time

B. *The following questions refer to work NOW.*

33. If not working, why? Date last worked: _____
☐ too much pain ☐ medical restrictions ☐ can't concentrate ☐ too tired
☐ laid off

34. If you have returned to work:
☐ full-time ☐ part-time ☐ regular job ☐ modified job ☐ different job

35. Comparing your job ability before you had injury/pain problem, what can you do?
☐ as much as before ☐ somewhat less than before ☐ about half as much as before
☐ much less than before ☐ somewhat less than before ☐ not do the job at all

36. Do you have work restrictions?
☐ yes ☐ no Explain: _____

C. *Future goals and plans*

37. Are you going to school? ☐ yes ☐ no ☐ full-time ☐ part-time

38. What would you like to do? _____

39. Do you have future plans? _____

ACTIVITIES OF DAILY LIVING/FUNCTIONAL STATUS

These questions are about how your symptoms and health effect your activities now.

a. **Sexual function**
☐ interest _____

b. **Social/Recreational**
☐ participation in group activities
Now: _____
Before: _____

☐ sports/hobbies
Now: _____
Before: _____

What tasks are most difficult for you? _____

_____

40. Please describe activities you do on an average day.
☐ rest ☐ watch TV ☐ read ☐ light chores ☐ heavy chores ☐ clean house
☐ work ☐ look for work ☐ visit friends and family

SOCIAL/HABITS

41. 1) Do you use tobacco? ☐ yes ☐no Have you ever smoked? ☐ yes ☐ no
If yes: How many years? _____ Packs per day ____
When did you quit? _____ Do you want to stop? ____

2) Caffeine, please describe use.
_____

3) Alcohol use: How much? _____
How often? _____
Does alcohol cause any problems? _____
Were you alcoholic in the past? _____
When do you drink? _____

4) Nonprescription drug use (Describe): _____

5) Exercise - Please describe in detail: _____
_____
_____

6) Education completed:
☐ elementary school ☐ high school w/diploma or GED
☐ college degree ☐ advanced degree
☐ vocational training _____

7) Family - Are you: ☐ married ☐ single ☐ divorced ☐ widower ☐ separated

Marriage:

	Dates	Children/Age	Why ended
First			
Second			
Third			

If you have children, where are they now? _____

Overall, how happy are you with your family life?
☐ extremely happy ☐ happy ☐ not happy ☐ very unhappy

PAST/OTHER MEDICAL HISTORY

(The purpose of this section is to understand your overall general medical history and health care status.)

1) Family Members' History

		If yes, Who?
Similar problem to yours?	☐ yes ☐ no	
Disability	☐ yes ☐ no	
Arthritis	☐ yes ☐ no	
Heart disease	☐ yes ☐ no	
Diabetes	☐ yes ☐ no	
Drug abuse	☐ yes ☐ no	
Alcoholism	☐ yes ☐ no	

(Your Medical History)

2) **Hospitalisations:**

Year	Illness/Operation	Remaining problems

3) **Previous Trauma** (automobile accident, fractures, strains, any other):

Date	Injury/Accident	Remaining problems

5) **Allergies** (medication or environmental): _____

6) **Medications** (please all medications you take - even if only occasional)

Medication	Dose	How often	When started	Why?

7) **Previous worker's compensation or personal injury:**

Date	Injury	Company	PI/WC	Work time lost	Disability Rating	How settled

STRESS MANAGEMENT

42. After reading each symptom, write the number that best corresponds with how you felt during the past several days. Use this formula: 0=not at all; 1=somewhat; 2=moderately; and 3=a lot.

(1) ☐ Sadness: Have you been feeling blue or "down in the dumps"?

(2) ☐ Irritability, frustration: Have you been feeling resentful and angry a good deal of the time?

(3) ☐ Low self-esteem: Have you been feeling inadequate or worthless?

(4) ☐ Loss of interest in life: Have you lost interest in your career, hobbies or daily activities?

(5) ☐ Loss of interest in people: Have you lost interest in your friends, family or spouse?

(6) ☐ Loss of Motivation: Have you needed to push yourself hard to do things? Have you been procrastinating?

(7) ☐ Guilt: Have you been blaming yourself for your weaknesses, shortcomings or mistakes?

(8) ☐ Sleep changes: ☐ Have you had difficulty falling asleep and sleeping soundly?
Fatigue ☐ Have you been excessively tired and sleeping too much?
☐ falling asleep _____
☐ quality of sleep _____
☐ staying asleep _____
☐ awakening early _____
total restful hours: ____ _____

(9) ☐ Loss of libido: Have you lost interest in sex? Are people whom you once found attractive no longer appealing to you?

(10) ☐ Suicidal impulses: Have you though that life is not worth living and that you would rather be dead? Have you been having suicidal fantasies or impulses or making suicide plans?. (If your answer indicates that you have suicidal urges, you should immediately seek help from a mental health professional.)

43. With your present income are you?
☐ unable to pay your bills ☐ able to pay for all necessities
☐ comfortable ☐ destitute
☐ worried about future income

44. What is the status of your legal proceedings?
☐ none filed ☐ pending ☐ resolved

_____
_____
_____

45. Is your injury or pain affecting your relationship with:

your spouse? ☐ yes ☐ no _____

46. your children? ☐ yes ☐ no _____

47. your co-workers/friends? ☐ yes ☐ no _____

MEDICAL REVIEW OF SYSTEMS

The following is a record of any symptoms you may have had in the past or are ongoing. Please check the appropriate boxes for each.

N = never O = occasional F= frequent

	N	O	F
General			
feeling hot	☐	☐	☐
feeling cold	☐	☐	☐
fatigue	☐	☐	☐
irritable	☐	☐	☐
nervous	☐	☐	☐
hot/cold	☐	☐	☐
chills	☐	☐	☐
sweats	☐	☐	☐
tremors	☐	☐	☐
weight gain	☐	☐	☐
weight loss	☐	☐	☐
Head/Neurologic			
headaches	☐	☐	☐
head injury	☐	☐	☐
neck injury	☐	☐	☐
dizziness	☐	☐	☐
convulsions	☐	☐	☐
slurred speech	☐	☐	☐
memory loss	☐	☐	☐
concentration problem	☐	☐	☐
weakness	☐	☐	☐
strokes	☐	☐	☐
carpal tunnel	☐	☐	☐
Bones/Joints			
arthritis	☐	☐	☐
bursitis	☐	☐	☐
tendinitis	☐	☐	☐
cramps/spasms	☐	☐	☐
swollen joints	☐	☐	☐
pain between shoulders	☐	☐	☐
back pain	☐	☐	☐
chiropractic treatment	☐	☐	☐
dislocations	☐	☐	☐
gout	☐	☐	☐
stiffness	☐	☐	☐
osteoporosis	☐	☐	☐
pain or numbness in:			
shoulders	☐	☐	☐
arms	☐	☐	☐
elbows	☐	☐	☐
wrists	☐	☐	☐
hands	☐	☐	☐
hips	☐	☐	☐
legs	☐	☐	☐
knees	☐	☐	☐
feet	☐	☐	☐
painful tailbone	☐	☐	☐
poor posture	☐	☐	☐
sciatica	☐	☐	☐
spinal curvature	☐	☐	☐

	N	O	F
Eyes			
glasses	☐	☐	☐
blurry vision	☐	☐	☐
double vision	☐	☐	☐
eye pain	☐	☐	☐
Ears			
ringing/buzzing	☐	☐	☐
drainage	☐	☐	☐
motion sickness	☐	☐	☐
loss of hearing	☐	☐	☐
Face/Throat			
sinusitis	☐	☐	☐
frequent colds	☐	☐	☐
hoarseness	☐	☐	☐
problems swallowing	☐	☐	☐
pain on chewing	☐	☐	☐
pain in your jaw(s)	☐	☐	☐
dentures	☐	☐	☐
problems smelling	☐	☐	☐
Lungs			
Tuberculosis	☐	☐	☐
asthma	☐	☐	☐
pneumonia	☐	☐	☐
shortness of breath	☐	☐	☐
chronic cough	☐	☐	☐
wheezing	☐	☐	☐
blood clots	☐	☐	☐
rapid breathing	☐	☐	☐
Heart			
palpitations	☐	☐	☐
rapid heart rate	☐	☐	☐
chest pain	☐	☐	☐
high blood pressure	☐	☐	☐
shortness of breath:			
w/activity	☐	☐	☐
lying down	☐	☐	☐
leg cramps (walking)	☐	☐	☐
swollen feet/ankles	☐	☐	☐
Circulation			
varicose veins	☐	☐	☐
blood clots	☐	☐	☐
easy bleeding	☐	☐	☐
anemia	☐	☐	☐
Skin			
pain	☐	☐	☐
itching	☐	☐	☐
dryness	☐	☐	☐
eczema	☐	☐	☐
rashes	☐	☐	☐