



# UPSTATE INJURY CENTER

(864) 552-1142

2520 Wade Hampton Blvd  
Suite B  
Greenville, SC 29615

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

No  Yes When?

Patient Number (office use only)

Whom may we thank for referring you?

If so, whom?

Your Last Name

Your Social Security Number

Birth Date (MM/DD/YYYY)

Age

Your First Name

Your Middle Name (or Initial)

Gender

Male  Female

Race

Address

Marital Status  Married

Ethnicity

Single  Divorced

City

State/Province

ZIP/Postal Code

Widowed  Separated

Preferred Language

Home Phone

Cell Phone

Spouse's Name

Email Address

Child's Name and Age

Emergency Contact

Emergency Contact's Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

Work Phone

Address

May we contact you at work?

Yes  No

City

State/Province

ZIP/Postal Code

Preferred method of contact?

Home Phone  Cell Phone

Primary Care Provider's Name

Work Phone  Email

Insurance Carrier

Policy Number

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?

Self  Spouse  Parent

Insured's First Name

Insured's Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

CONFIDENTIAL HEALTH INFORMATION



Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Familial adenomatous polyposis (FAP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lynch Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unknown Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Kidney Disease (assoc. Diabetes Type 2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Nephrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nephritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nephrotic Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unknown Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Lower Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OCD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Panic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personality Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PTSD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Phobia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Septicemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/Brain Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sudden Infant Death Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PATIENT HISTORY**

Please describe your past accidents:

1. Accident: \_\_\_\_\_ Job Auto Other Date: \_\_\_\_\_

2. Accident: \_\_\_\_\_  Job  Auto  Other Date: \_\_\_\_\_  
 3. Accident: \_\_\_\_\_  Job  Auto  Other Date: \_\_\_\_\_

Please describe your past surgeries:  
 1. Surgery: \_\_\_\_\_ Date: \_\_\_\_\_  
 2. Surgery: \_\_\_\_\_ Date: \_\_\_\_\_  
 3. Surgery: \_\_\_\_\_ Date: \_\_\_\_\_

Do you have any implants?  Yes  No If yes, please describe \_\_\_\_\_

Are you currently pregnant?  Yes  No If yes, please list your due date: \_\_\_\_\_

Please indicate which conditions **YOU** (the patient) have experienced by marking the boxes below.

AIDS	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	Bladder Trouble	<input type="checkbox"/>	Bone Fracture	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Concussion	<input type="checkbox"/>	Constipation	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Dislocated Joints	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	German Measles	<input type="checkbox"/>	Headache	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Herniated Disk	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	HIV/ARC	<input type="checkbox"/>	Kidney Disorder	<input type="checkbox"/>	Loss of Bowel Control	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	Menstrual Cramps	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>
Muscular Dystrophy	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	Numbness	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	Parkinson's disease	<input type="checkbox"/>	Pinched Nerve	<input type="checkbox"/>	Polio	<input type="checkbox"/>
Poor circulation	<input type="checkbox"/>	Reproductive disorder	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	Serious Injury	<input type="checkbox"/>
Sinus Trouble	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Tumors or Growths	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	_____	<input type="checkbox"/>

**SYMPTOMS**

**On the following pages you will be asked to choose your symptoms from this list.**

Neck Pain	Upper Back Pain	Mid Back Pain	Low Back Pain
Left Shoulder Pain	Right Shoulder Pain	Left Hip Pain	Right Hip Pain
Left Knee Pain	Right Knee Pain	Left Leg Pain	Right Leg Pain
Stiff Neck	Headache	Left Hand Pain	Right Hand Pain

**IMPAIRED ACTIVITIES**

**To go with each symptom you are reporting, you will be asked to select the MAIN activity that is made more difficult by each symptom. Choose the activity out of the options below.**

Computer Use (extended)	Computer Use (Short time)	Concentrating	Cycling
Desk Work	Drawing	Driving	Exercise
Lying Down	Piano	Reading	Running
Sitting	Standing	Staying Asleep	Using the Phone
Walking	Yard Work	Bathing	Bending
Caring for Infirm Person	Cervical Range of Motion	Child Care	Climbing Stair
Falling Asleep	Dressing	Golf	Hair Care
Kneeling	Lifting	Lifting Children	Lifting/Carrying Groceries
Looking over Shoulder	Lying Down	Needlework	Pet Care
Sexual Activities	Shaving	Sitting	Swimming

## SYMPTOMS

Please fill out the form below to describe your current symptoms.

### SYMPTOM 1

Symptom (choose ONE from list on previous page):

Pain rating (1-10, with 10 being worst imaginable):

1    2    3    4    5    6    7    8    9    10

Main impaired activity made more difficult by above symptom (choose ONE from list on previous page):

<p><b>Pain Quality:</b></p> <input type="checkbox"/> Aching <input type="checkbox"/> Burning <input type="checkbox"/> Cramping <input type="checkbox"/> Deep <input type="checkbox"/> Diffuse <input type="checkbox"/> Dull <input type="checkbox"/> Numbness <input type="checkbox"/> Radiating <input type="checkbox"/> Sharp <input type="checkbox"/> Shooting <input type="checkbox"/> Stiffness <input type="checkbox"/> Tight <input type="checkbox"/> Tingling	<p><b>Pain Frequency:</b></p> <input type="checkbox"/> Constant <input type="checkbox"/> Frequent <input type="checkbox"/> Intermittent <input type="checkbox"/> Occasional	<p><b>Pain radiates into:</b></p> <input type="checkbox"/> Left Arm <input type="checkbox"/> Left Foot <input type="checkbox"/> Left Hand <input type="checkbox"/> Left Leg <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Arm <input type="checkbox"/> Right Foot <input type="checkbox"/> Right Hand <input type="checkbox"/> Right Leg <input type="checkbox"/> Right Shoulder <input type="checkbox"/> Other: _____	<p><b>Pain Cause:</b></p> <input type="checkbox"/> A Fall <input type="checkbox"/> Work Injury <input type="checkbox"/> Auto Accident <input type="checkbox"/> Illness <input type="checkbox"/> Lifting Injury <input type="checkbox"/> Unknown <input type="checkbox"/> Gradual Onset
	<p><b>Pain Pattern:</b></p> <input type="checkbox"/> Better in Morning <input type="checkbox"/> Better in Afternoon <input type="checkbox"/> Better in Evening <input type="checkbox"/> Worse in Morning <input type="checkbox"/> Worse in Afternoon <input type="checkbox"/> Worse in Evening <input type="checkbox"/> Consistent <input type="checkbox"/> Unchanged	<p><b>What has been done before to treat this symptom?</b></p> <input type="checkbox"/> Acupuncture <input type="checkbox"/> Prescription medicine <input type="checkbox"/> Massage <input type="checkbox"/> Surgery <input type="checkbox"/> OTC Medicines	<p><b>Pain Duration:</b></p> <input type="checkbox"/> _____ Day(s) <input type="checkbox"/> _____ Week(s) <input type="checkbox"/> _____ Month(s) <input type="checkbox"/> _____ Year(s)
<p><b>Pain aggravated by:</b></p> <input type="checkbox"/> Bending <input type="checkbox"/> Driving <input type="checkbox"/> Getting up/down <input type="checkbox"/> Increased Activity <input type="checkbox"/> Looking down <input type="checkbox"/> Overhead activities <input type="checkbox"/> Reaching <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Typing		<p><b>Pain relieved by:</b></p> <input type="checkbox"/> Exercise <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Knees Bent Up <input type="checkbox"/> Lying Down <input type="checkbox"/> No Movement <input type="checkbox"/> Resting <input type="checkbox"/> Standing <input type="checkbox"/> Support <input type="checkbox"/> Walking	

**For Doctor's Use Only:**

What restrictions relate to the main impaired activity for this symptom?