COMPREHENSIVE HEALTH CLINICS
137 2ND AVE. SW, CAMBRIDGE, MN 55008

763-689-2462
FAX: 763-689-1688

PHQ

What is your chief problem or symptom? _____

What caused the problem or symptom to occur? _____

When did the problem or symptom begin (Date of injury)? _____

Have you seen another doctor for this problem? _____

What tests/procedures have been performed? _____

Have you had this problem or symptoms in the past? _____

Have you tried any other treatments for this? _____

Is the problem or symptoms getting worse? _____

PAIN EVALUATION & DRAWING

Circle location(s) of your symptoms on body drawing. Outline using the symbols for the type of sensation.

Pain	: : : : : : : : : :
Numbness	+ + + + + + +
Burning	/ / / / / / / / /
Ache	X X X X X

Describe your pain (check all that apply):

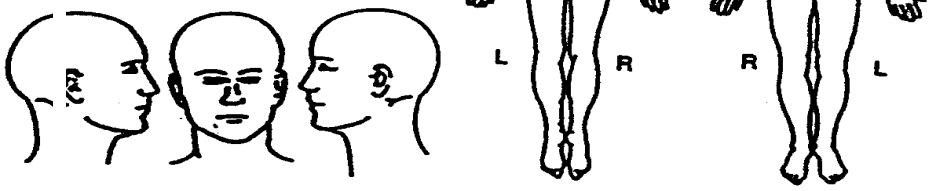
- □ Constant
- □ Intermittent
- □ Recurring
- □ Stabbing
- □ Dull Ache
- □ Sharp
- □ Deep Ache
- □ Throbbing
- □ Tingling
- □ While Resting
- □ Daily
- □ During Exercise
- □ Nightly
- □ _____

Cause of Pain:

- □ Traumatic _____
- □ Chronic _____
- □ Post Surgical
- □ Work Related
- □ Motor Vehicle
- □ School Sports
- □ Unknown

Onset of Pain:

- □ Sudden
- □ Gradual



On a scale of 1 to 10 how would you rate your pain OR discomfort level? _____ (1 = Mild, 10 = Intense)

How much has pain interfered with your normal work (including both work outside the home, and housework)
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

In general would you say your overall health right now is: □ Excellent □ Very Good □ Good □ Fair □ Poor

What if anything gives you relief? _____

_____

What irritates it or makes it worse? _____

_____

--If this is a Work or AUTO related PLEASE proceed to back side—

_____
Print Name of Patient

X _____

Signature (if minor, parent must sign) Date

_____
Provider Signature

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IF YOUR PROBLEM OR SYMPTOMS ARE DUE TO AN AUTO ACCIDENT OR WORK INJURY PLEASE COMPLETE

□ **Automobile Accident**

Date & Time of Accident _____

Describe how accident occurred and what happened to your body motion at the time of the accident.

_____

_____

_____

How did you feel 24 hours before the accident?

□ FINE — NO PAIN □ _____

Were you the	□ Driver	□ Passenger
Others in car	□ No	□ Yes
Were they hurt	□ No	□ Yes
Did you brace for impact	□ No	□ Yes
Wearing seat belt	□ No	□ Yes
Using shoulder harness	□ No	□ Yes
Wearing eye glasses	□ No	□ Yes
Where was your car struck	□ Behind	□ Front/Side
Was your car breaking	□ No	□ Yes
Damage to vehicle	□ Minimal	□ Moderate
Was car totaled	□ No	□ Yes
Did seat back break	□ No	□ Yes
Did glass break	□ No	□ Yes
Police report made	□ No	□ Yes
Did you go to E.R.	□ No	□ Yes
Had accident before	□ No	□ Yes
Missed any work	□ No	□ Yes

What was the road conditions like? _____

What was the visibility at the time? _____

For insurance purposes please complete:

Your auto insurance co _____

Phone number _____

This claim number _____

Your attorney _____

Telephone number _____

□ **Work Related Injury**

Date & Time of Injury _____

Describe how injury occurred in your own words. Be specific in details & accurate in pains & injuries.

_____

_____

_____

How did you feel 24 hours before this injury?

□ FINE — NO PAIN □ _____

Was injury report made	□ No	□ Yes
Report to supervisor	□ No	□ Yes
Missed any work	□ No	□ Yes
Any work injury before	□ No	□ Yes
Seen company doctor	□ No	□ Yes
Authorized to see us	□ No	□ Yes

List your routine job duties in detail

_____

_____

_____

For insurance purposes please complete:

Employer Company _____

Your WC insurance _____

Your Claim# _____

Soc. Sec# _____

Adjuster Name _____

Adjusters phone number _____

Attorney Name & Phone _____

_____

Print Name of Patient

X _____ _____

Signature (if minor, parent must sign) Date

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