



First & Last Name _____ Middle Initial _____ Nickname _____

Address _____ Age _____ Birth Date _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Social Security # _____ E-mail _____

Employer's Name _____ Position _____

Employer's Address _____

Marital Status – circle one: {S M W D} Number of Children _____ Are You Insured? Y / N

Auto Ins. Company _____ Claim Number _____

Telephone Contact: _____ Do you have AFLAC accident insurance? Y / N

Spouse's Name _____ Are you Pregnant? Y / N

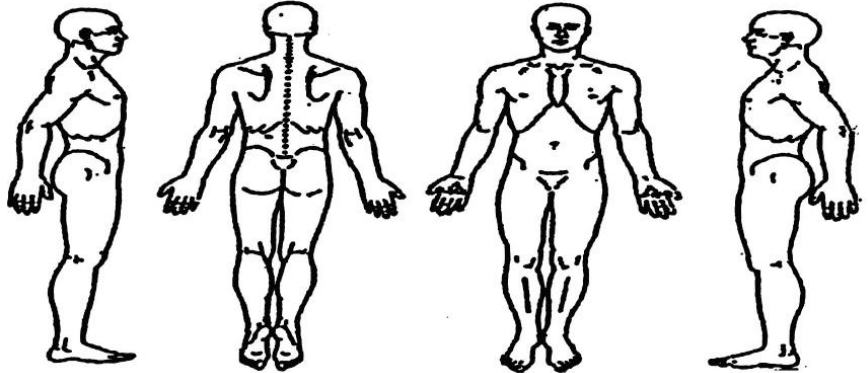
Referred by _____ If minor, Parents Names _____

1. Is today's problem caused by an automobile accident or work accident/injury? No Yes
(If YES, Please Notify Front Desk Assistant)

2. Indicate on the drawings below where you have pain/symptoms:

Main Complaint:

Other Complaints:



3. What concerns you the most about your problem?

4. Do you consider this problem to be severe?

- Yes Yes, at times No

5. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

6. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

7. Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician
- ER physician Orthopedist Other: _____
- Massage Therapist Physical Therapist No one

8. What is your: Height _____ Weight _____ Occupation _____

9. How would you rate your overall Health? Excellent Very Good Good Fair Poor

10. What type of exercise do you do? Strenuous Moderate Light None

11. Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis Diabetes Lupus
- Heart Problems Cancer ALS

12. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss		
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite		For Females Only
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular In coordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		

13. List all prescription medications you are currently taking: _____

14. List all of the over-the-counter medications and/or supplements you are currently taking: _____

15. List all surgical procedures you have had: _____

16. What activities do you do at work?

- Sit: Most of the day Half the day A little of the day
- Stand: Most of the day Half the day A little of the day
- Computer work: Most of the day Half the day A little of the day
- On the phone: Most of the day Half the day A little of the day

17. What activities do you do outside of work? _____

18. Have you ever been hospitalized? No Yes

If yes, why _____

19. Have you had any past falls, traumas, or automobile accidents? No Yes

If yes, explain _____

20. Have you ever been diagnosed with osteoporosis or osteopenia? No Yes

21. Have you ever been diagnosed with cancer? No Yes

If yes, explain _____

22. List 3 activities that you are find difficult or are unable to perform due to this condition.

23. Has this condition affected your bowel or bladder habits? No Yes

If yes, how _____

24. Have you visited a chiropractor before? No Yes

If yes, when was your last visit? _____

25. Anything else pertinent to your visit today? _____

Financial Policy: Full Payment is due at the time of service. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that when my account becomes 45 days past due, it is the policy of this office to forward it to TekCollect for collection. At such time, I will be subject to collection charges and further collection activity.

If I am a patient with insurance coverage, I understand and agree that medical insurance policies are an arrangement between my insurance company and myself - not my insurance company and this office. I authorize this office to release any medical information and complete any usual and customary reports and forms at no charge, to assist in collecting from my insurance company. Not all insurance pays all of the charges, and the patient will be responsible for his/her portion at the time the services are rendered. If my insurance company deems care not medically necessary, the balance will be my responsibility. I understand that I am ultimately responsible for payment in full.

I have read this financial policy. I understand and agree to all the terms of this policy.

Signature: X _____ Date: _____
(Parent signature if minor)

Consent to X-Ray: I herby authorize Baker Chiropractic & Rehab, LLC and whomever the clinician my designate as his assistant(s) to take any needed x-rays. If I am a female, I herby state that I am not pregnant. *(If for any reason you may possibly be pregnant, please discuss this with the doctor before signing below.)* I understand that if I request, copies of my x-rays may be made at a \$20 copy charge. X-rays may be sent to any location at a shipping and handling fee of \$15.

I herby consent to x-ray.

Signature: X _____ Date: _____
(Parent signature if minor)

Name: _____ Date: _____

Patient: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the letter of the **ONE CHOICE** that most applies to you **before the accident**. We realize that you may feel that more than one statement may relate to you, but **ONLY** circle the one choice which closely describes your problem right now.

Pre-Accident Neck Disability Index

SECTION 1--Pain Intensity

- A. I have no pain at the moment
- B. The pain is mild at the moment.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain is severe but comes and goes.
- F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)

- A. I can look after myself without causing extra pain.
- B. I can look after myself normally but it causes extra pain.
- C. It is painful to look after myself and I am slow and careful.
- D. I need some help, but manage most of my personal care.
- E. I need help every day in most aspects of self-care.
- F. I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3--Lifting

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, but it causes extra pain.
- C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
- D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E. I can lift very light weights.
- F. I cannot lift or carry anything at all.

SECTION 4 --Reading

- A. I can read as much as I want to with no pain in my neck.
- B. I can read as much as I want with slight pain in my neck.
- C. I can read as much as I want with moderate pain in my neck.
- D. I cannot read as much as I want because of moderate pain in my neck.
- E. I cannot read as much as I want because of severe pain in my neck.
- F. I cannot read at all.

SECTION 5--Headache

- A. I have no headaches at all.
- B. I have slight headaches which come infrequently.
- C. I have moderate headaches which come in-frequently.
- D. I have moderate headaches which come frequently.
- E. I have severe headaches which come frequently.
- F. I have headaches almost all the time.

Raw Score: _____

DISABILITY INDEX SCORE: _____%

SECTION 6 -- Concentration

- A. I can concentrate fully when I want to with no difficulty.
- B. I can concentrate fully when I want to with slight difficulty.
- C. I have a fair degree of difficulty in concentrating when I want to.
- D. I have a lot of difficulty in concentrating when I want to.
- E. I have a great deal of difficulty in concentrating when I want to.
- F. I cannot concentrate at all.

SECTION 7--Work

- A. I can do as much work as I want to.
- B. I can only do my usual work, but no more.
- C. I can do most of my usual work, but no more.
- D. I cannot do my usual work.
- E. I can hardly do any work at all.
- F. I cannot do any work at all.

SECTION 8--Driving

- A. I can drive my car without neck pain.
- B. I can drive my car as long as I want with slight pain in my neck.
- C. I can drive my car as long as I want with moderate pain in my neck.
- D. I cannot drive my car as long as I want because of moderate pain in my neck.
- E. I can hardly drive my car at all because of severe pain in my neck.
- F. I cannot drive my car at all.

SECTION 9--Sleeping

- A. I have no trouble sleeping
- B. My sleep is slightly disturbed (less than 1 hour sleepless).
- C. My sleep is mildly disturbed (1-2 hours sleepless).
- D. My sleep is moderately disturbed (2-3 hours sleepless).
- E. My sleep is greatly disturbed (3-5 hours sleepless).
- F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10--Recreation

- A. I am able engage in all recreational activities with no pain in my neck at all.
- B. I am able engage in all recreational activities with some pain in my neck.
- C. I am able engage in most, but not all recreational activities because of pain in my neck.
- D. I am able engage in a few of my usual recreational activities because of pain in my neck.
- E. I can hardly do any recreational activities because of pain in my neck.
- F. I cannot do any recreational activities at all.

Name: _____ Date: _____

Patient: This questionnaire is designed to enable us to understand how much your back pain has affected your ability to manage everyday activities. Please answer each Section by circling the letter of the **ONE CHOICE** that most applies to you *before the accident*. We realize that you may feel that more than one statement may relate to you, but **ONLY** circle the one choice which closely describes your problem right now.

Pre-Accident Back Disability Index

SECTION 1--Pain Intensity

- A. The pain comes and goes and is very mild.
- B. The pain is mild and does not vary much.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain is severe but comes and goes.
- F. The pain is severe and does not vary much.

SECTION 2--Personal Care

- A. I would not have to change my way of washing or dressing in order to avoid pain.
- B. I do not normally change my way of washing or dressing even though it causes some pain.
- C. Washing and dressing increase the pain, but I manage not to change my way of doing it.
- D. Washing and dressing increase the pain and I it necessary to change my way of doing it.
- E. Because of the pain, I am unable to do any washing and dressing without help.
- F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3--Lifting

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, but it causes extra pain.
- C. Pain prevents me from lifting heavy weights off the floor.
- D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
- E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- F. I can only lift very light weights, at the most.

SECTION 4 --Walking

- A. Pain does not prevent me from walking any distance.
- B. I have some pain on walking but it does not increase with distance.
- C. Pain prevents me from walking more than one mile.
- D. Pain prevents me from walking more than 1/2 mile.
- E. I can only walk while using a cane or on crutches.
- F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5--Sitting

- A. I can sit in any chair as long as I like without pain.
- B. I can only sit in my favorite chair as long as I like.
- C. Pain prevents me from sitting more than one hour.
- D. Pain prevents me from sitting more than 1/2 hour.
- E. Pain prevents me from sitting more than ten minutes.
- F. Pain prevents me from sitting at all.

SECTION 6 -- Standing

- A. I can stand as long as I want without pain
- B. I have some pain while standing, but it does not increase with time.
- C. I cannot stand for longer than one hour without increasing pain.
- D. I cannot stand for longer than ½ hour without increasing pain.
- E. I can't stand for more than 10 minutes without increasing pain.
- F. I avoid standing because it increases pain right away.

SECTION 7--Sleeping

- A. I get no pain in bed.
- B. I get pain in bed, but it does not prevent me from sleeping.
- C. Because of pain , my normal night's sleep is reduced by less than one-quarter.
- D. Because of pain, my normal night's sleep is reduced by less than one-half.
- E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
- F. Pain prevents me from sleeping at all.

SECTION 8--Social Life

- A. My social life is normal and gives me no pain.
- B. My social life is normal, but increases the degree of my pain.
- C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- D. Pain has restricted my social life and I do not go out very often.
- E. Pain has restricted my social life to my home.
- F. Pain prevents me from sleeping at all.

SECTION 9--Traveling

- A. I get no pain while traveling.
- B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
- C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- D. I get extra pain while traveling which compels me to seek alternative forms of travel.
- E. Pain restricts all forms of travel.
- F. Pain prevents all forms of travel except that done lying down.

SECTION 10--Changing Degree of Pain

- A. My pain is rapidly getting better.
- B. My pain fluctuates, but overall is definitely getting better.
- C. My pain seems to be getting better, but improvement is slow at present.
- D. My pain is neither getting better nor worse.
- E. My pain is gradually worsening.
- F. My pain is rapidly worsening.

Raw Score _____

DISABILITY INDEX SCORE: _____ %

Name: _____ Date: _____

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Post-Accident Neck Disability Index

SECTION 1--Pain Intensity

- A. I have no pain at the moment
- B. The pain is mild at the moment.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain is severe but comes and goes.
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- D. My pain is neither getting better nor worse.
- E. My pain is gradually worsening.
- F. My pain is rapidly worsening.

Raw Score _____

DISABILITY INDEX SCORE: _____ %

Name: _____ Date: _____

Auto Accident Information

Date of accident: _____ Time of Accident: _____ am / pm

Your role was (circle one): Back seat passenger / Front seat passenger / Driver of motorcycle /
Driver with both hands on the wheel / Driver with (left/right) hand on the wheel / Other: _____

What was the vehicle's status (circle one)? Accelerating / At a stop light / Attempting to stop / Changing lanes /
Driving down the road / Driving in parking lot / Moving / Moving at moderate speed / Moving at speed limit /
Moving in reverse / Parked / Sliding out of control (weather related) / Slowing down / Speeding / Spinning out of
control (weather related) / Stopped / Turning Other: _____

What area of the vehicle was impacted (circle one)? Driver side / Front bumper / Front driver side corner / Front
passenger corner / Passenger side / Rear bumper / Rear driver side corner / Rear passenger side corner / Rear trailer
/ Totaled and head on collision / Other: _____

It was (circle one): Dawn / Dusk / Full Daylight / Night

Road conditions were (circle one): Damp / Dry / Icy Covered / Nasty / Snow covered / Wet /
Other: _____

Rate the visibility (circle one): Excellent, Fair, Good, Poor

What type was the other vehicle involved (circle one)? Compact Car / Full Size Car / Large Pickup Truck / Large SUV
/ Motorcycle / Semi / Small SUV / Other: _____

What would you guess was the speed of the other vehicle? (end in 0 or 5) _____

In what position was your headrest (circle one)? High / Middle / Low / Unknown

Were you admitted to a hospital? Yes / No If yes, circle one: At the time of the accident / At a later time

How did you get to the hospital (circle one)? Ambulance / Life Flight / Police Car / Private Transportation /
Other: _____

What was your attending doctor's name? _____

How many days were you in the hospital? _____

Choose one: _____ I was able to brace for impact with my (hands, feet, or knees).
_____ I was aware the accident was coming, but unable to brace.
_____ I was not aware the accident was impending.

Circle the problem for the accident (circle one): Brightness, Darkness, Fog, Rain, Snow, Traffic

Where are your injuries (circle all that apply)?

Back of Head	Front of Neck	Left Shin	Right Elbow	Right Wrist
Back of Neck	Left Arm	Left Shoulder	Right Hand	Side of Face
Chest	Left Elbow	Left Wrist	Right Hip	Side of Head
Fingers on Left Hand	Left Hand	Low Back	Right Knee	Side of Neck
Fingers on Right Hand	Left Hip	Mid Back	Right Leg	Upper Back
Forehead	Left Knee	Nose	Right Shin	
Front of Face	Left Leg	Right Arm	Right Shoulder	

Symptoms

Please check all symptoms you currently have *that you did not have before the accident.*

- | | | | |
|---|--|-------------------------------|--------------------------------|
| <input type="checkbox"/> Sleepiness | <input type="checkbox"/> Frustration | | |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Wanting to be alone | | |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Fatigue | | |
| <input type="checkbox"/> Seizure | <input type="checkbox"/> Hearing Problems | | |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Change in sense of taste | | |
| <input type="checkbox"/> Suddenly start dreaming | <input type="checkbox"/> Change in sense of smell | | |
| <input type="checkbox"/> Mindless staring | <input type="checkbox"/> Sleeping problems | | |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Difficulty with hand coordination | | |
| <input type="checkbox"/> Agitation | <input type="checkbox"/> Difficulty planning or organizing | | |
| <input type="checkbox"/> Sadness | <input type="checkbox"/> I am more easily distracted | | |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Social withdrawal | | |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Feeling isolated | | |
| <input type="checkbox"/> Disoriented | <input type="checkbox"/> "Clunk" sound with neck movements | | |
| <input type="checkbox"/> Confused | <input type="checkbox"/> Jaw pain | | |
| <input type="checkbox"/> Difficulty speaking | <input type="checkbox"/> Clicking jaw | | |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pain when chewing | | |
| <input type="checkbox"/> Attention problems | <input type="checkbox"/> Numbness in arms or hands | | |
| <input type="checkbox"/> Appetite change | <input type="checkbox"/> Numbness in legs or feet | | |
| <input type="checkbox"/> Pupils different sizes | <input type="checkbox"/> Tingling in arms or hands | | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Tingling in legs or feet | | |
| <input type="checkbox"/> Balance problems | <input type="checkbox"/> Weakness in arms or hands | | |
| <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Weakness in legs or feet | | |
| <input type="checkbox"/> Groggy | <input type="checkbox"/> Neck pain | | |
| <input type="checkbox"/> Very tired | <input type="checkbox"/> Upper back pain | | |
| <input type="checkbox"/> Dozing during the day | <input type="checkbox"/> Low back pain | | |
| <input type="checkbox"/> Personality change | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Can't remember numbers | <input type="checkbox"/> Upper arm pain | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Reading problems | <input type="checkbox"/> Elbow pain | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Writing problems | <input type="checkbox"/> Forearm pain | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Difficulty with adding/subtracting | <input type="checkbox"/> Wrist pain | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Poor Attention | <input type="checkbox"/> Hand pain | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Difficulty learning new things | <input type="checkbox"/> Hip pain | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Difficulty understanding | <input type="checkbox"/> Upper leg pain | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Difficulty remembering | <input type="checkbox"/> Knee pain | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Re-reading things to understand it | <input type="checkbox"/> Lower leg pain | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Ankle pain | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Difficulty making decisions | <input type="checkbox"/> Foot pain | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Slurred speech | <input type="checkbox"/> Face pain | | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Chest pain | | |
| <input type="checkbox"/> Change in sexual functioning | <input type="checkbox"/> Stomach pain | | |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Bruise to _____ | | |
| <input type="checkbox"/> Reduced confidence | <input type="checkbox"/> Scrape/cut to _____ | | |
| <input type="checkbox"/> Helplessness | <input type="checkbox"/> Other symptom _____ | | |
| <input type="checkbox"/> Apathy (Don't care) | <input type="checkbox"/> Other symptom _____ | | |
| <input type="checkbox"/> Irritable | | | |
| <input type="checkbox"/> Flashbacks to accident | | | |
| <input type="checkbox"/> Impatience | | | |