

Patient Basic Information

Personal Information:

Last Name:		First Name:	Mid. Init.:
Address:		City, State, Zip:	
Home Phone:	Work Phone:	Social Security No.:	
Date of Birth:		Date of Injury/Onset:	
Dominant Hand:		<input type="checkbox"/> Right	<input type="checkbox"/> Left <input type="checkbox"/> Both
Insurance Information: Policy Holder (if different than patient):		Policy No.:	

Special Note: If your injury involved a motor vehicle, skip to page 2. Otherwise, use the spaces below to fully describe your accident, injury or onset, slip and fall, etc.

1. Description of Accident/Injury/Onset

Enter a full description of the accident, injury or onset in the space below.

2. Your condition during and immediately after injury/onset

Enter the details of your condition during and immediately after your injury/onset.

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type

Car Station Wagon
 Van Pickup Truck
 Large Truck Bus
 Other _____

2. Your position in vehicle

Driver Front Passenger
 Left Rear Passenger
 Right Rear Passenger
 Other _____

3. What was your vehicle doing at the time of the accident?

Stopped at intersection Stopped in traffic Stopped at light
 Making a right turn Making a left turn Parking
 Proceeding along Slowing down Accelerating
 Other _____

4. Time/Speed/Damage

Time of accident _____
 Your vehicle's speed: _____ mph
 Their vehicle's speed: _____ mph

Damage to your vehicle

Mild Moderate
 Totaled

5. Details of Accident

Visibility at time of accident
 Poor Fair Good

Who hit who/what?
 You hit other vehicle
 Other vehicle hit you

You hit...(object)

6. Road conditions

Road conditions at time of accident
 Icy Wet Sandy Dark Clean and dry

Point of impact
 Head-On Left Front Right Front
 Read-End Left Rear Right Rear

7. Body Position, etc.

Did you see the accident coming? Yes No
 Were you braced for the impact? Yes No
 Did you have a seat belt on? Yes No
 Did you have a shoulder harness on? Yes No

Does your vehicle have headrests? Yes No
What was the position of your headrest at the time of the impact?
 Even with top of head Even with bottom of head Middle of neck
What was the direction of your head at the time of the impact?
 Facing straight forward Turned to the right Turned to the left

Did driver side air bags deploy? Yes No Did passenger side airbags deploy? Yes No Did side airbags deploy? Yes No

8. Additional accident information

In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

9. During the accident:

Did your body strike the inside of your vehicle? Yes No
 If yes, describe: _____
 Did you lose consciousness during the injury? Yes No
 If yes, for how long? _____
 Your vehicle's estimated damage? _____
Damage to their vehicle: Mild Moderate Totaled
 Did police show up at the scene? Yes No
 Was an accident report filled out? Yes No

10. After the accident:

Check off your symptoms right after and a few days following:
 Headache Dizziness Mid back pain Cold hands
 Neck pain Nausea Low back pain Cold feet
 Neck stiffness Confusion Nervousness Diarrhea
 Fainting Fatigue Loss of taste Depression
 Ringing in ears Tension Toe numbness Anxious
 Loss of smell Irritability Constipation Chest Pain
 Pain behind eyes Shortness of breath Sleeping problems
 Others: _____

11. Emergency Room?

Where did you go after the accident?
 Home Work Hospital ER Private Doctor
How did you get there?
 Drove self Somebody else Ambulance Police
Were X-rays done? Yes No **Was lab work done?** Yes No
 Body parts X-rayed? _____
 What lab work? _____
 The X-rays revealed: _____
Treatments: Cervical Collar Ice **Other:** _____
 Medications: _____
 Follow-up instructions: _____

12. Treatment History:

Fill in any other doctor(s) seen prior to your first visit to this office.
1. Dr. _____ First visit date: ____/____/____
 Specialty: _____ X-rays done? Yes No
 Types of treatments received: _____
 How many treatments received? ____ Currently treating? Yes No
 Did treatments benefit you? Yes No
 Last visit date: ____/____/____
2. Dr. _____ First visit date: ____/____/____
 Types of treatments received: _____
 How many treatments received? ____ Currently treating: Yes No
 Did treatments benefit you? Yes No
 Last visit date: ____/____/____

Activities/ Daily Living Assessment

Please check all that apply

Section 1 – Pain Intensity:

- Pain comes and goes and is mild
- Pain is mild and does not vary
- Pain comes and goes and is moderate
- Pain is moderate and does not vary much
- Pain comes and goes and is severe
- Pain is severe and does not vary much

Section 6 – Standing:

- Can stand for an unlimited time without pain
- Some pain standing/ doesn't increase w/time
- Cannot stand for more than 1 hour
- Cannot stand for more than 1/2 hour
- Cannot stand for more than 10 minutes
- Cannot stand at all

Section 2 – Personal Care:

- Do not change habits to avoid pain
- Do not change habits but experience some pain
- Do not change habits but it increases pain
- Do change habits due to increased pain
- Unable to do some personal care without help
- Unable to wash or dress without help

Section 7 – Sleeping:

- No pain in bed
- Gets pain in bed/ but sleeps well
- Normal sleep reduced by 1/4
- Normal sleep reduced by 1/2
- Normal sleep reduced by 3/4
- Cannot sleep at all due to pain

Section 3 – Lifting

- Lifts heavy weights with no pain
- Lifts heavy weight with pain
- Cannot lift heavy weights off the floor
- Can lift heavy weight from a table
- Can lift light weights from a table
- Can lift only very light weights

Section 8 – Traveling

- Travel without pain
- Travel causes some pain, but not made worse
- Causes extra pain, no change in form
- Causes pain, uses alternative travel
- Pain restricts all forms of travel
- Pain restricts travel except lying down

Section 4 – Walking

- Pain does not prevent walking
- Cannot walk more than 1 mile
- Cannot walk more than 1/2 mile
- Cannot walk more than 1/4 mile
- Can only walk on crutches
- Bedridden and must crawl to the toilet

Section 9 – Social

- Normal and causes no pain
- Normal but causes extra pain
- Limits energetic interests
- Pain limits/ does not go out as often
- Pain restricts social life to home
- Pain restricts all social life

Section 5 – Sitting

- Can sit in any chair as long as desired
- Can sit only in certain chair as long as desired
- Can sit no more than 1 hour
- Can sit no more than 1/2 hour
- Can sit no more than 10 minutes
- Cannot sit at all due to pain

Section 10 – Changing Degree of Pain

- Pain is rapidly improving
- Pain fluctuates but is improving
- Improvement is slow
- Pain level is unchanged
- Pain is gradually worsening
- Pain is rapidly worsening

Score: _____ (For Office Use Only)

Description of Symptoms (Describe your symptoms in the sections below, in the order of severity, if possible.)

I. First Current Symptom: (Please check off the boxes below to describe your first symptom. Describe only ONE symptom per Section)

<p>1. Check only one body location below</p> <p><input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Front of Head</p> <p><input type="checkbox"/> Top of Head</p> <p><input type="checkbox"/> Back of Head</p> <p><input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p>Other locations: _____</p>	<p>2. 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<p>3. Pain Frequency</p> <p><input type="checkbox"/> Up to 1/4 of awake time <input type="checkbox"/> 1/4 to 1/2 of time</p> <p><input type="checkbox"/> 1/2 to 3/4 of awake time <input type="checkbox"/> Most all the time</p>	<p>4. Pain Intensity (How it affects your daily activities)</p> <p><input type="checkbox"/> Doesn't affect <input type="checkbox"/> Somewhat affects</p> <p><input type="checkbox"/> Seriously affects <input type="checkbox"/> Prevents activities</p>																																																																	
<p>5. Does this pain radiate into other body parts?</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Left</th> <th>Right</th> <th>Both</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> Head</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Neck</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Shoulder</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Arm</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Hand</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Hip</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Leg</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Foot</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table> <p>Other locations of radiation: _____</p>				Left	Right	Both	<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																												
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II. Second Current Symptom: (Please check off the boxes below to describe your next symptom).

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III. Third Current Symptom: (Please check off the boxes below to describe your 3rd symptom).

<p>1. Check only one body location below</p> <p><input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Front of Head</p> <p><input type="checkbox"/> Top of Head</p> <p><input type="checkbox"/> Back of Head</p> <p><input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p>Other locations: _____</p>	<p>2. 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Description of Symptoms

(Describe your symptoms in the sections below, in the order of severity, if possible.)

IV. Fourth Symptom: (Please check off the boxes below to describe your 4th symptom. Describe only ONE symptom per Section.)																																																															
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Description of Symptoms

(Describe your symptoms in the sections below, in the order of severity, if possible.)

VII. Seventh Symptom: (Please check off the boxes below to describe your 7th symptom. Describe only ONE symptom per Section.)

<p>1. Check only one body location below</p> <p><input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p style="padding-left: 20px;"><input type="checkbox"/> Front of Head</p> <p style="padding-left: 20px;"><input type="checkbox"/> Top of Head</p> <p style="padding-left: 20px;"><input type="checkbox"/> Back of Head</p> <p><input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p>Other locations: _____</p>	<p>2. Types of pain</p> <p><input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Aching <input type="checkbox"/> Cutting</p> <p><input type="checkbox"/> Throbbing <input type="checkbox"/> Burning <input type="checkbox"/> Numbing <input type="checkbox"/> Tingling <input type="checkbox"/> Cramping</p> <p><input type="checkbox"/> Spasm <input type="checkbox"/> Stinging <input type="checkbox"/> Shooting <input type="checkbox"/> Pounding <input type="checkbox"/> Constricting</p> <p style="text-align: right;">Other types of pain: _____</p>	<p>3. Pain Frequency</p> <p><input type="checkbox"/> Up to 1/4 of awake time <input type="checkbox"/> 1/4 to 1/2 of time</p> <p><input type="checkbox"/> 1/2 to 3/4 of awake time <input type="checkbox"/> Most all the time</p>	<p>6. Actions affecting this pain</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Brings On</th> <th style="text-align: center;">Aggravates</th> <th style="text-align: center;">Relieves</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> In the A.M.</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> In the P.M.</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Bending forward</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> 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VIII. Eighth Current Symptom: (Please check off the boxes below to describe your 8th symptom.)

<p>1. Check only one body location below</p> <p><input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p style="padding-left: 20px;"><input type="checkbox"/> Front of Head</p> <p style="padding-left: 20px;"><input type="checkbox"/> Top of Head</p> <p style="padding-left: 20px;"><input type="checkbox"/> Back of Head</p> <p><input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p>Other locations: _____</p>	<p>2. 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Other Actions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
<p>4. Pain Intensity (How it affects your daily activities)</p> <p><input type="checkbox"/> Doesn't affect <input type="checkbox"/> Somewhat affects</p> <p><input type="checkbox"/> Seriously affects <input type="checkbox"/> Prevents activities</p>	<p>5. Does this pain radiate into other body parts?</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Left</th> <th style="text-align: center;">Right</th> <th style="text-align: center;">Both</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> Head</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Neck</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Shoulder</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Arm</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Hand</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Hip</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Leg</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Foot</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> </tbody> </table> <p>Other locations of radiation: _____</p>		Left	Right	Both	<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																														
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