NMS Symptoms

Patient Name_____ **Date:** _____

Date of Injury (DOI) _____

Place a check on the line in the first (1st) column if you had any of these symptoms ***before*** the collision.
Place a check on the line in the second (2nd) column if you had any of these symptoms ***after*** the collision.
Place a check on the line in the third (3rd) column if you are experiencing any of these symptoms ***today***.

Head, Face and Neck Pain	**Before DOI**	**After DOI**	**Today**
Headache - right/left/front/back/top	_____	_____	_____
Face - right/left	_____	_____	_____
Upper Neck - right/left/front/back	_____	_____	_____
Lower Neck - right/left/front/back	_____	_____	_____

Back Pain	**Before DOI**	**After DOI**	**Today**
Upper Back - right/left/midline	_____	_____	_____
Middle Back - right/left/midline	_____	_____	_____
Lower Back - right/left/midline	_____	_____	_____
Pelvis - right/left/midline	_____	_____	_____

Upper Body Pain	**Before DOI**	**After DOI**	**Today**
Shoulders - right/left/front/back	_____	_____	_____
Arms - right/left	_____	_____	_____
Hands - right/left	_____	_____	_____
Fingers - right/left	_____	_____	_____

Lower Body Pain	**Before DOI**	**After DOI**	**Today**
Hips - right/left	_____	_____	_____
Thighs - right/left	_____	_____	_____
Legs - right/left	_____	_____	_____
Feet - right/left	_____	_____	_____

Thank you for taking the time to fill out this form as completely as possible. Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient's physical, mental and emotional state.

Patient's Signature _____ Date_____

Guardian's Signature _____ Date_____

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