

CLIENT NAME: _____

1. Age: _____
2. Sex: _____
3. Height: _____
4. Weight _____
5. List All Medications you are Currently Taking: _____
6. List All Medications Taken in Last 6 Months: _____
7. List all Medications including Over the Counter drugs taken with 24 hours of arrest:

Eyes

- 8.1 Do You wear glasses _____
- 8.2 When was the last time your eyes were checked? _____
- 8.3 On the date of your arrest, did you do anything that would cause eye strain? _____
- 8.4 If So, What: _____
- 8.5 Have you ever been diagnosed with Eye Muscle Fatigue? _____
- 8.6 Have you been diagnosed with Dry Eyes? _____
- 8.7 Have you been diagnosed with conjunctivitis? _____
- 8.8 Have you been diagnosed or treated for Glaucoma? _____
- 8.9 Do you have a "Lazy Eye" or are you "Crossed Eyed?" _____
- 8.10 Are you under the care of an Ophthalmologist? _____
 - 8.10.1 Name of Doctor: _____
 - 8.10.2 Condition _____
- 8.11 On the day of your arrest had you ingested:
 - 8.11.1 Caffeine: _____
 - 8.11.2 Nicotine _____
 - 8.11.3 Aspirin _____
 - 8.11.4 Antihistamines _____
 - 8.11.5 Other _____
- 8.12 On the day of your arrest, did you have or had you had suffered from:
 - 8.12.1 The flu or cold _____
 - 8.12.2 Hypotension _____
 - 8.12.3 Hypertension _____
 - 8.12.4 Arteriosclerosis _____
 - 8.12.5 Streptococcus Infection _____
 - 8.12.6 Measles _____
 - 8.12.7 Muscular Dystrophy _____
 - 8.12.8 Multiple Sclerosis _____
 - 8.12.9 Epilepsy _____
 - 8.12.10 Brain Hemorrhage _____
 - 8.12.11 Inner Eye Injury _____
 - 8.12.12 Bilateral Amblyopia _____
 - 8.12.13 Unusual Sleep Pattern _____

- 8.12.14 Vertigo _____
- 8.12.15 Dyslexia _____
- 8.12.16 Any other eye problem _____

Ears/Hearing

- 9.1 Do you wear a hearing aid? _____
- 9.2 Do you have any diagnosed hearing defects? _____
 - 9.2.1 If so, please explain: _____
- 9.3 Do you have any diagnosed auditory processing defects? _____
 - 9.3.1 If so, please explain: _____
- 9.4 Have you had an inner ear infections? _____
- 9.5 Have you suffered any injury to your ears? _____
 - 9.5.1 If so, please explain: _____
- 9.6 Do you get swimmer's ear? _____

Body Temperature

- 10.1 What is your normal body temperature? _____
- 10.2 On the day of your arrest what was your body temperature? _____
- 10.3 Within 24 hours of your arrest did you have a fever? _____
- 10.4 Did you have your period or were you premenstrual at the time of your arrest? _____

Lungs and Respiratory System

- 11.1 Do you have Asthma? _____
- 11.2 Do you have Pulmonary Obstructive Disease? _____
- 11.3 Do you smoke? _____
 - 11.3.1 How much per day? _____
- 11.4 Do you have lung cancer? _____
- 11.5 Do you have Lymphoma? _____
- 11.6 Do you have Hodgkins Disease? _____
- 11.7 Do you have throat cancer? _____
- 11.8 Do you have any other diagnosed ailment of the respiratory system? _____

Endocrine System

- 12.1 Are you diabetic? _____
 - 12.1.1 Type I? _____
 - 12.1.2 Type II? _____
 - 12.1.3 Do you take Insulin? _____
 - 12.1.4 Are you on oral medication? What: _____
- 12.2 On the day of your arrest were you hypoglycemic? _____
- 12.3 On the day of your arrest were you hyperglycemic? _____
- 12.4 Have you ever had yeast infections? _____
- 12.5 Where you taking antibiotics on the day of your arrest? _____

Gastronintestinal System

- 13.1 Gastric Reflux Disease: _____
- 13.2 Esophaghea Hernia: _____
- 13.3 Heartburn: _____
- 13.4 Do you use Tagament, Zantac or other anti-heart burn medication? _____

- 13.4.1 If so, what: _____
13.5 Do you suffer from any urinary track infections? _____
13.6 Do you suffer from bladder infections? _____

Physical Condition

Have you ever suffered injuries to or have deformities in your:

- 14.1.1 Feet _____
14.1.2 Ankles _____
14.1.3 Knees _____
14.1.4 Legs _____
14.1.5 Back _____
14.1.6 Spine _____
14.1.7 Hands or Fingers _____
14.1.8 Neck _____
14.2 Do you suffer from Arthritis? _____
14.3 Are you "Pigeon Toed"? _____
14.4 Are you "Bow Legged"? _____
15. Muscular System

Muscular System

At the time of your arrest did you have any muscle:

- 15.1.1 Strains _____
15.1.2 Sprains _____
15.1.3 Tears _____
15.1.4 Atrophy _____
15.1.5 Cramps _____
15.2 Have you ever suffered any disease of the muscles? _____
15.3 Do you have Ataxia? _____
15.4 Do you have any condition that you believe effects your balance and coordination? What:

Circulatory System

- 16.1 Do you have heart disease? _____
16.2 Do you take any blood thinners? _____
17. Neurological/Psychological/Psychiatric
17.1 Have you ever suffered a stroke? _____
17.2 Have you ever suffered an injury to the brain? _____
17.3 Have you ever seen a psychologist or a psychiatrist? _____
17.3.1 What was diagnosis: _____
17.3.2 When: _____
17.3.3 Were you placed on medication? What: _____
17.4 Have you been diagnosed with Attention Deficit Disorder? _____
17.5 Do you suffer from Depression? _____
17.6 Do you experience Anxiety Attacks? _____
17.7 Do you get nervous easily? _____

For Accident Cases

- 18.1 Did you hit your head? _____

- 18.2 Were you injured in any way? _____
18.2.1 If so, how: _____
18.3 Were you wearing a seatbelt? _____
18.4 Did you air bag deploy? _____
18.5 Were you taken to the hospital? _____
18.6 Were you put on an IV prior to having your blood withdrawn? _____
18.7 Do you remember talking with a police officer? _____
18.8 Did you ever lose consciousness? _____

The Mouth

- 19.1 Do you have periodontal disease? _____
19.2 Do you have dentures? _____
19.3 Do you have any extensive Bridge work? _____
19.4 Do you have any caps or crowns which are loose? _____
19.5 Do you have any condition which introduces blood into your mouth? _____
19.6 Were you on antihistamines on the day of your arrest? _____

General Information

- 20.1 Do you have any condition that would affect your ability to perform field sobriety tests? What: _____
20.2 Do you have any condition that would make you appear to be intoxicated? What: _____
20.3 Were you pepper sprayed or sprayed with mace? _____

Contact Information

Please list the name, addresses and phone numbers for all physicians you have been treated by relevant to any issues above. For additional doctors, please use reverse.

Primary Care Physician:

Name: _____
Address: _____
Phone: _____

Specialist: _____

Name: _____
Address: _____
Phone: _____

Dentist: _____

Name: _____
Address: _____
Phone: _____