David Bennett, DC
CHIROPRACTOR

David Bennett, D.C.
901 Douglas Ave STE 100
Altamonte Springs, FL 32714
407-660-1200

CONFIDENTIAL PATIENT CASE HISTORY

Today's Date

NAME:________________________ SOCIAL SECURITY #:__________ - ______ - __________

ADDRESS:________________________ DATE OF BIRTH: ________ / ______ / __________ Age

SUITE / APT:________________________ OCCUPATION:________________________

CITY:________________________ EMPLOYER:________________________

STATE:______________ ZIP:__________ MARRIED / SINGLE: Spouse's Name?______________

PHONE HOME / CELL :________________________ EMERGENCY CONTACT:________________________

PHONE WORK:________________________ EMERGENCY CONTACT PH:________________________

E-MAIL:________________________ WHO MAY WE THANK FOR REFERRING YOU TO US?

____ FRIEND / FAMILY (NAME) ?____ WEB SITE ? ____ SEARCH ENGINE? ____ PHONE BOOK?

CHIEF COMPLAINT: ____

____ Date of injury / illness

If your complaints are NOT auto related, please skip this section & continue to page 2.

AUTO CRASH HISTORY

Type of accident: Auto Truck Bus Taxi Van Motorcycle Other: ____________

Where were you hit from?: Front Rear Left side Right side Top Other:____________

Were you the : Driver Passenger A pedestrian Riding a bike Other?____________

What did you strike? Head Rest Seat Window Door Dashboard Steering wheel Ground Pole Other:____________

Did you / were you: Trip Mugged Slip-n-Fall Hit by falling object Other:____________

What body part was injured? Head Neck Upper back Low back Arms Legs Knees Elbows

Did you strike your: Head Neck Back Arms Legs Hands Feet

Were there any cuts or bruises? ____

Did you lose consciousness? Yes No If yes, for how long?________________________

Were you taken to the hospital? Yes No If yes, which one?________________________

Were you kept overnight (admitted)? Yes No If yes, for how long?________________________

What treatment did you receive at the hospital? Medication Arm sling Neck collar Crutches Other:____________

Were X-rays taken? Yes No If yes, what was x-rayed?________________________

CURRENT HEALTH STATUS

Do you have a family Medical Doctor? No Yes If yes, may we send him / her your treatment records? No yes

Dr's. Name
Address
Phone:

What doctors have you seen since this incident / illness?

	Name	Specialty	Date
1.			
2.			
3.			

What have you done at home for this condition? Nothing Ice / heat Rest Pain Medication

What professional treatment has been done thus far? None Neck Collar Physical Therapy Manipulation Ice / Heat Braces Ultrasound Other:________________

What are your present symptoms? None Nausea Vomiting Dizziness Fainting Vision Problems Nervousness Weakness in Arms / Legs Numbness in Arms / Legs

Pain in the: Head Neck Upper back Lower back Chest Abdomen Shoulders Arms Hands Legs Knees Feet

Difficulty with: Walking Bending Sitting Sleeping Moving of Arms / Legs Other:________________

Since this mishap / crash, have your symptoms become: Worse No improvement Better Slightly better Very much better

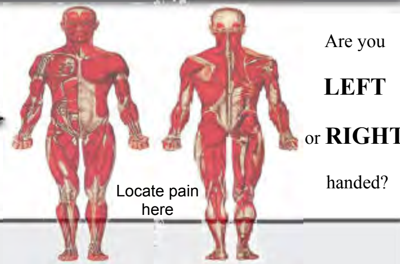
Were you on-the-job when this mishap / crash occurred? No Yes If yes, what were you doing at the time? ____________

____

Have you lost any work due to this mishap / crash? No Yes If yes, how many: Days? Weeks? Months?

Please indicate your degree of symptoms from "0" (no pain) to "10" (extreme pain).

No Pain												Ext Pain
Headaches:	0	1	2	3	4	5	6	7	8	9	10	
Neck or Arms:	0	1	2	3	4	5	6	7	8	9	10	
Upper Back:	0	1	2	3	4	5	6	7	8	9	10	
Lower Back or Legs:	0	1	2	3	4	5	6	7	8	9	10	



Are you **LEFT** or **RIGHT** handed?

PAST HISTORY:

Have you ever been under chiropractic care **prior** to this complaint? No Yes If yes, when? ________________

and for what condition? ____

Did you ever have a similar condition / accident? No Yes If yes, when? ________________________

Have you ever had any serious illness? No Yes If yes, please describe: ________________________

____

Do you require medication? No Yes If yes, please identify type:________________________

Have you ever had surgery? No Yes If yes, please list type and date below:

1.

2.

3.

Please sign and date this document and acknowledge receiving a copy of your HIPAA Privacy Policy of this office.

Thank You!

Signature & Date