AUTOMOBILE ACCIDENT HISTORY

DATE _____

NAME:_____ SS#:_____
LAST FIRST MI

ADDRESS:_____HOME PHONE: _____

CITY:_____ STATE:_____ ZIP:_____ CELL PHONE:_____

BIRTHDATE :_____( )MALE ( )FEMALE ( )SINGLE ( )MARRIED ( )DIVORCED ( )WIDOWED

EMPLOYER:_____PHONE:_____

SPOUSE'S NAME:_____ DOB:_____SPOUSE'S SS#: _____

SPOUSE'S EMPLOYER:_____ EMPLOYER PHONE: _____

EMERGENCY CONTACT:_____PHONE: _____

Due to HIPPA regulations we will not discuss financial or medical records with anyone but our patient. If you would like to give our office authorization to discuss financial and/or medical records with your spouse or any other party please list their name and relation: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

NAME OF PRIMARY CARE PHYSICIAN: _____ PHONE: _____

INSURANCE INFORMATION

THEIRS

Insurance Company_____

Insured Party_____

Insurance Company Contact _____Phone _____

Policy No._____Claim No._____

Vehicle Driver_____

YOURS

Insurance Company_____

Insured Party_____

Insurance Company Contact _____Phone _____

Policy No._____Claim No._____

Vehicle Driver_____

Name of Health Insurance_____Group & ID# _____

Time and date of accident _____ ❑ AM ❑ PM ____/____/____

Please explain in detail how your accident occurred?_____

_____

You were heading? ❑ North ❑ South ❑ East ❑ West on_____(street or highway)

Other vehicle was heading? ❑ North ❑ South ❑ East ❑ West on_____(street or highway)

Number of people with you in the car?_____

Were police notified? ❑ Yes ❑ No Did head strike windshield or object? ❑ Yes ❑ No

Did you lose consciousness? ❑ Yes ❑ No If so, for how long?_____

You were struck from ? ❑ Behind ❑ Front ❑ Left Side ❑ Right Side

You were? ❑ Driver ❑ Passenger ❑ Front seat ❑ Backseat, Using ❑ Seat belt ❑ Shoulder belt ❑ Other protective devices

Did you feel pain immediately after the accident? ❑ Yes ❑ No ❑ Later that day ❑ Next day ❑ When _____

What were your immediate symptoms following the accident?_____

Where were you taken after the accident? ❑ Home ❑ Emergency Room ❑ Other, _____

What treatment was rendered? _____

Was any doctor(s) consulted after the accident? ❑ Yes ❑ No

If so, give doctor's name_____ ❑ D.C. ❑ M.D. ❑ D.O. ❑ D.D.S.

Doctor's diagnosis?_____ Did you see the doctor(s) more than once?_____

Have you ever had any complaints in the involved area before? ❑ Yes ❑ No

If so, were they due to ❑ A previous car accident, or ❑ On the job injury?

Before the injury, were you capable of working on an equal basis with others your age? ❑ Yes ❑ No

Are your work activities restricted as a result of this accident? ❑ Yes ❑ No

Since the injury, are your symptoms ❑ Improving? ❑ Getting worse? ❑ The same?

Have you retained an attorney? ❑ No ❑ Yes, Name_____Phone _____

Vehicle Make & Model you were in_____Estimated Damage $ _____

Vehicle Description that hit you _____

HEALTH QUESTIONNAIARE

PLEASE CHECK (✓) CONDITIONS YOU ARE CURRENTLY EXPERIENCING

MUSCULO-SKELETAL SYSTEM

- ❑ Low back pain
- ❑ Mid back pain
- ❑ Pain between shoulders
- ❑ Neck pain
- ❑ Disc problems
- ❑ Arm problems
- ❑ Leg problems
- ❑ Swollen joints
- ❑ Painful joints
- ❑ Stiff joints
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Walking problems
- ❑ Muscle spasms
- ❑ Broken bones
- ❑ Shoulder pain
- ❑ Carpal Tunnel

GENITO-URINARY SYSTEM

- ❑ Bladder trouble
- ❑ Excessive urination
- ❑ Scanty urination
- ❑ Painful urination
- ❑ Discolored urine

FEMALE

- ❑ Vaginal discharge
- ❑ Vaginal bleeding
- ❑ Vaginal pain
- ❑ Breast pain
- ❑ Lumps on the breast

GASTRO-INTESTINAL SYSTEM

- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Difficult chewing
- ❑ Difficult swallowing
- ❑ Excessive thirst
- ❑ Nausea
- ❑ Vomiting Blood
- ❑ Abdominal pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black stool
- ❑ Bloody stool
- ❑ Hemorrhoids
- ❑ Liver trouble
- ❑ Gall bladder problems
- ❑ Weight trouble

NERVOUS SYSTEM

- ❑ Numbness
- ❑ Loss of feeling
- ❑ Paralysis
- ❑ Dizziness
- ❑ Fainting
- ❑ Headaches
- ❑ Muscles jerking
- ❑ Convulsions
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Insomnia / Loss of sleep

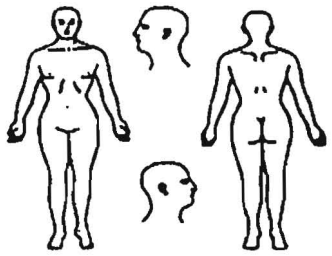
HABITS

- ❑ Cigarettes
- ❑ Alcohol Abuse
- ❑ Coffee or Tea
- ❑ Exercise
- ❑ Drug Abuse
- ❑ _____

ARE YOU PREGNANT?

❑ YES ❑ NO

Please mark your area of pain on the figure below.



P ___ Pain N ___ Numb

S ___ Spasm

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Most

CARDIO-VASCULAR RESPIRATORY

- ❑ Chest pain
- ❑ Pain over heart
- ❑ Difficult breathing
- ❑ Persistent cough
- ❑ Coughing phlegm
- ❑ Coughing blood
- ❑ Rapid heartbeat
- ❑ Blood pressure problems
- ❑ Heart problems
- ❑ Lung problems
- ❑ Varicose veins

EYE, EAR, NOSE AND THROAT

- ❑ Eye strain
- ❑ Eye inflammation
- ❑ Vision problems
- ❑ Ear pain
- ❑ Ear noises
- ❑ Ear discharge
- ❑ Hearing loss
- ❑ Nose pain
- ❑ Nose bleeding
- ❑ Nose discharge
- ❑ Difficult breathing through nose
- ❑ Sore gums
- ❑ Dental problems
- ❑ Sore mouth
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficult speech
- ❑ Sinus
- ❑ Allergy
- ❑ Jaw pain

	Y	N
Do you have diabetes?	❑	❑
Is problem worse while lying down?	❑	❑
Have you recently had fever, sweats, chills?	❑	❑
Does this problem wake you from a sound sleep?	❑	❑

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature: _____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers' compensation carriers, welfare funds, or the patient's employer.

Patient's Signature: _____

Parent's or Guardian's Signature: _____