

MOTOR VEHICLE ACCIDENT HISTORY

PATIENT NAME:		DATE:
ADDRESS:	CITY:	STATE/ZIP CODE:
HOME PHONE NUMBER:	CELL PHONE NUMBER:	
DATE OF BIRTH:	AGE:	GENDER:
EMERGENCY CONTACT NAME:		EMERGENCY CONTACT PHONE NUMBER:
EMPLOYER NAME:	EMPLOYER ADDRESS:	
ACCIDENT INFORMATION		
DATE OF ACCIDENT:	TIME OF ACCIDENT:	WHERE WERE YOU LOCATED IN THE VEHICLE AT THE TIME OF THE ACCIDENT? <input type="checkbox"/> DRIVER <input type="checkbox"/> PASSENGER <input type="checkbox"/> FRONT SEAT <input type="checkbox"/> BACK SEAT
NUMBER OF PEOPLE IN THE CAR:	NAMES OF PEOPLE IN THE CAR WITH YOU:	
WHAT DIRECTION WAS YOUR CAR HEADED? <input type="checkbox"/> NORTH <input type="checkbox"/> SOUTH <input type="checkbox"/> EAST <input type="checkbox"/> WEST	ON WHAT STREET WERE YOU HEADED?	
WHAT DIRECTION WAS THE OTHER CAR HEADED? <input type="checkbox"/> NORTH <input type="checkbox"/> SOUTH <input type="checkbox"/> EAST <input type="checkbox"/> WEST	WERE YOU STRUCK FROM: <input type="checkbox"/> BEHIND <input type="checkbox"/> FRONT <input type="checkbox"/> LEFT SIDE <input type="checkbox"/> RIGHT SIDE	
WERE YOU KNOCKED UNCONSCIOUS? <input type="checkbox"/> YES <input type="checkbox"/> NO	DID YOU HIT YOUR HEAD? <input type="checkbox"/> YES <input type="checkbox"/> NO	
WHERE WERE YOU TAKEN AFTER THE ACCIDENT?		BY AMBLANCE: <input type="checkbox"/> YES <input type="checkbox"/> NO
WHAT TYPE OF VEHICLE WERE YOU IN? <input type="checkbox"/> TRUCK <input type="checkbox"/> CAR <input type="checkbox"/> SUV <input type="checkbox"/> VAN <input type="checkbox"/> SEMI	OTHER	
WHAT TYPE OF VEHICLE WERE THEY IN? <input type="checkbox"/> TRUCK <input type="checkbox"/> CAR <input type="checkbox"/> SUV <input type="checkbox"/> VAN <input type="checkbox"/> SEMI	OTHER	
WERE THE POLICE ON THE SCENE? <input type="checkbox"/> YES <input type="checkbox"/> NO	WAS A REPORT FILED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOU HAVE A COPY? <input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU BEEN TREATED BY ANY OTHER DOCTORS FOR THIS INJURY/ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	SINCE THE INJURY, ARE YOUR SYMPTOMS: <input type="checkbox"/> IMPROVING <input type="checkbox"/> GETTING WORSE <input type="checkbox"/> GETTING BETTER	
HAVE YOU LOST TIME FROM WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE YOU LEFT WORK:	DATE YOU RETURNED TO WORK?
HAVE YOU BEEN INVOLVED IN AN ACCIDENT IN THE PAST? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE DESCRIBE:	
DO YOU HAVE ANY PREVIOUS ILLNESSES WHICH RELATE TO THIS CASE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE DESCRIBE:	
DO YOU HAVE ANY ACTIVITY RESTRICTIONS AS A RESULT OF THIS INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE DESCRIBE:	
INSURANCE INFORMATION		
INSURANCE COMPANY NAME:	INSURANCE COMPANY PHONE:	
ADJUSTER NAME:	ADJUSTER PHONE:	
POLICY NUMBER:	CLAIM NUMBER:	

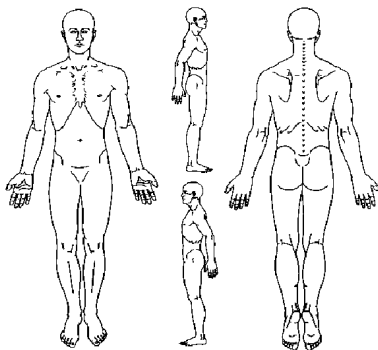
SYMPTOMS

INSTRUCTIONS: Check (✓) any/all symptoms noted after the accident.

- | | | |
|--|---|---|
| <input type="checkbox"/> HEADACHE | <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> LIGHT BOTHERS EYES |
| <input type="checkbox"/> NECK PAIN | <input type="checkbox"/> HEAD SEEMS HEAVY | <input type="checkbox"/> LOSS OF MEMORY |
| <input type="checkbox"/> NECK STIFFNESS | <input type="checkbox"/> PINS & NEEDLES IN ARMS | <input type="checkbox"/> EARS RING |
| <input type="checkbox"/> SLEEPING PROBLEMS | <input type="checkbox"/> PINS & NEEDLES IN LEGS | <input type="checkbox"/> FACE FLUSHED |
| <input type="checkbox"/> BACK PAIN | <input type="checkbox"/> NUMBNESS IN FINGERS | <input type="checkbox"/> BUZZING IN EARS |
| <input type="checkbox"/> NERVOUSNESS | <input type="checkbox"/> NUMBNESS IN TOES | <input type="checkbox"/> LOSS OF BALANCE |
| <input type="checkbox"/> TENSION | <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> FAINTING |
| <input type="checkbox"/> IRRITABILITY | <input type="checkbox"/> FATIGUE | <input type="checkbox"/> LOSS OF SMELL |
| <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> LOSS OF TASTE |
| <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> FEET FEEL COLD | <input type="checkbox"/> UPSET STOMACH |
| <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> HANDS FEEL COLD | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> FEVER | <input type="checkbox"/> COLD SWEATS | <input type="checkbox"/> OTHER: _____ |

INSTRUCTIONS: Please mark the area and type of pain on the drawings using the codes listed below:

N=Numbness P=Pain A=Ache T=Tingling S=Stiffness/Soreness



COMMENTS:

PLEASE PROVIDE ANY OTHER PERTINENT INFORMATION YOU THINK WE SHOULD KNOW:

SIGNATURE

PATIENT SIGNATURE:

DATE:

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Ownership of X-ray Films: *It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.*

SIGNATURE:	DATE:
GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE:	DATE:
WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?	
<input type="checkbox"/> PATIENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> WORKERS COMP <input type="checkbox"/> AUTO INSURANCE <input type="checkbox"/> MEDICARE <input type="checkbox"/> HEALTH INSURANCE	

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximal health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

SIGNATURE:	DATE:
Print Name:	DATE: