WELCOME!

Today's Date__________________

Name__________________________________ Date of Birth_______________ Phone_________________

What do you prefer to be called?______________________ Age_______ SS#____________________________

Address__________________________________ City_______________ State________ Zip_______________

Occupation____________________________________ Employer Name____________________________

Work Phone #_______________ Employer's Address____

Marital Status: ( )Single ( )Married ( )Divorced Spouse's Name___________________________________

Who may we thank for referring you to our office?____

Have you ever been treated by a Chiropractor?________ If so, whom?___________________________

INSURANCE INFORMATION

Insured's Name___________________________Relation_________________ Date of Birth_______________

Insured's SS#______________________ Insured's Employer__________________________________

Your Ins. Co.____ Policy #________________

Ins Co. Address____

Ins Co. Phone #____ Claim #____________________

NATURE OF ACCIDENT

Date of Accident_____________ Time of Day_______________ City/State_______________________________

Were you: ( )Driver ( )Passenger ( )Front Seat ( )Back Seat

Number of people in your vehicle?____________ Other Vehicle______________________________________

What direction were you looking?____________ Did you see the accident coming?________________________

Were you wearing a seat belt? ______ Did you hit anything in the car?_______ If yes, What__________________

Were you knocked unconscious? ____________ If yes, how long? ______________________________________

Were the police notified? ( )Yes ( )No

Have you retained an attorney? ( )Yes ( )No If yes, name:_______________________________________

In your own words, please describe the accident:____

____

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____

What are your present complaints and symptoms? (Please include a description of the pain and its location)___________

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Drs. Notes____

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On a scale of 0-10 please rate your pain (0=no pain, 10=extreme pain)___________________________________

Did you have any physical complaints BEFORE the accident? ( )Yes ( )No If yes, please describe:________________

____

____

Do you have any previous illness, injury, or congenital (from birth) factors which may relate to this problem?

( )Yes ( )No If yes, please describe____

____

Please describe how you felt: During the accident____

Immediately after the accident:____

Later that day____

The next day____

Have you ever been involved in an accident before? ( )Yes ( )No If yes, please describe________________________

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Have you been treated by any doctor since the accident? ( )Yes ( )No If yes, whom?____________________

Were x-rays taken? ( )Yes ( )No Was medication prescribed? ( )Yes ( )No

What activities have been restricted as a result of this injury?________________________________

____

Since this injury, are your symptoms: ( )Improving ( )Worse ( )Same

Have you lost time from work as a result of this accident? ( )Yes ( )No

Do you have a prior history of similar complaints?_______If yes, dates, prior treatment, results,etc.___________

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Drs. Notes: ____

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CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

☐ Headache	☐ Irritability	☐ Numbness in toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Sleeping Problems	☐ Loss of Balance	☐ Stomach Upset
☐ Fatigue	☐ Depression	☐ Head seems too heavy	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Tingling in arms	☐ Light bothers eyes	☐ Loss of Smell	☐ Diarrhea
☐ Nervousness	☐ Tingling in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Ears ring	☐ Numbness in Fingers	☐ Cold Sweats	☐ __________

PAST MEDICAL HISTORY

Have you ever had any of the following diseases/medical conditions?

__Heart Attack/Stroke	__Heart Surgery/Pacemaker	__Heart Murmur
__Congenital Heart Defect	__Mitral Valve Prolapse	__Artificial Valves
__Alcohol/Drug Abuse	__Venereal Disease	__Hepatitis
__HIV+/ Aids	__Shingles	__Cancer
__Frequent Neck Pain	__Emphysema/Glaucoma	__Anemia
__High/Low Blood Pressure	__Psychiatric Problems	__Rheumatic Fever
__Severe/Frequent Headaches	__Kidney Problems	__Ulcers/Colitis
__Fainting/Seizures/Epilepsy	__Sinus Problems	__Asthma
__Diabetes/Tuberculosis	__Difficulty Breathing	__Chemotherapy
__Lower Back Problems	__Artificial Bones/Joints	__Arthritis
__Hypothyroid	__Hyperthyroid	

Please List any other serious medical condition(s) you have or ever had:____

____

Please list anything that you may be allergic to____

List previous surgeries/treatment with dates:____

____

List any past serious accidents with dates:____

____

Family Health History:____

____

____

For Women: Are you Pregnant? ( )Yes ( )No Nursing? ( )Yes ( )No Date of Last Menses:___/___/___

Are you taking any of the following medications?

__Nerve Pills __Pain Killers (Including Aspirin) __Muscle Relaxants __Stimulants
__Blood Thinners __Tranquilizers __Insulin __Birth Control Pill __Other__________________

HABITS & ACTIVITY

Do you smoke? ( )yes ( )no Have you ever smoked? ( )yes ( )no How many packs per day?______________

Do you drink alcohol? ( )Yes ( )No Have you ever abused alcohol? Amount/Type_________________________

Do you drink caffeinated beverages? ( )Yes ( )No How much and type:___________________________

Exercise: ( ) None ( )Light ( )Moderate ( )Heavy Do you feel you eat a well balanced diet? ( ) Yes ( )No

Are you interested in a complete nutritional profile to assess your specific nutritional needs? ( )Yes ( )No

Are there any particular activities of daily living that you are having difficulty with due to your presenting complaint(s)?____

____

Drs.Notes:____

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IN THE EVENT OF EMERGENCY

Who should we contact?__________________________ Relation____________Phone #:___________________

Who is your Medical Doctor?____ Phone #__________________

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. You are responsible for your account balance.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

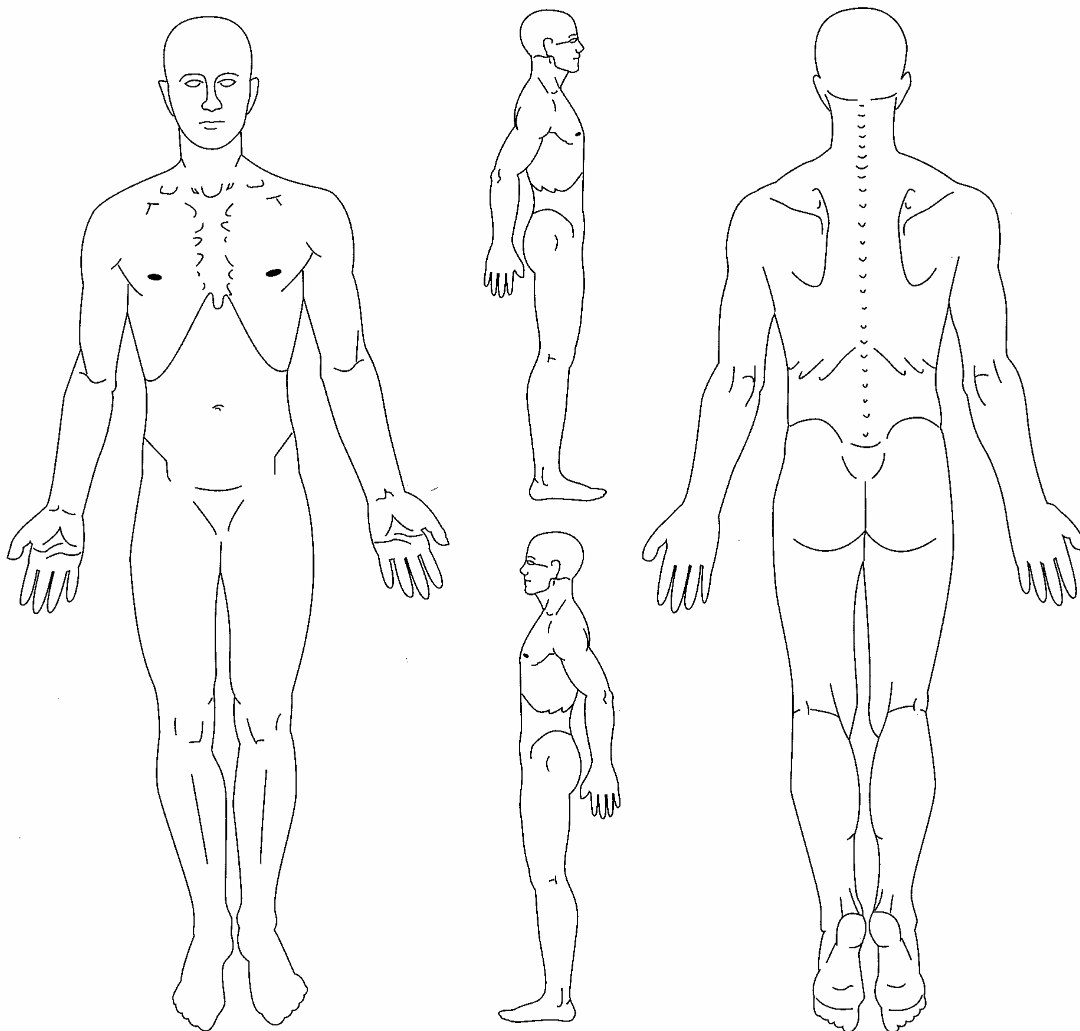
Signature____ Date_________________

Patient Name(Print)______________________________ Date____________

Patient ID #____________

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

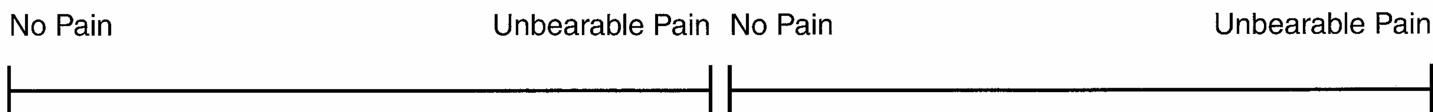
D = Dull
B = Burning
N = Numb
S = Stabbing/Cutting
T = Tingling (Pins & Needles)
C = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right **now:**

No Pain Unbearable Pain

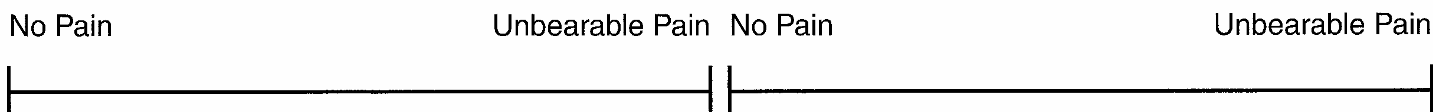


Rate your pain at its **best** in the past week:

No Pain Unbearable Pain

Rate your **average** pain in the past week:

No Pain Unbearable Pain



Rate your **worst** pain in the past week:

No Pain Unbearable Pain