CONFIDENTIAL PATIENT INFORMATION / Auto Accident

Name_____ SSN_____ Date _____

Address _____ City/State _____ Zip _____

D.O.B. _____ Height/Wt. _____ Home Phone _____

Employer _____ Occupation _____ Work Phone _____

Email _____Spouse/Partner _____

Whom May We Thank For Referring You to Us _____

Emergency Contact _____ Phone # _____

Date of Accident _____ Time of Accident _____AM/PM

Where Were You Seated _____ Approx. Damage to Car _____

Year/Make/Model of Your Car _____

Year/Make/Model of Other Car _____

Visibility at Time of Accident _____ Poor _____ Fair _____ Good

Road Conditions _____Dry _____Wet _____ Icy

Type of Accident (circle): Head On / Rear End / Broad Side / Pedestrian / Rear Ended Car in Front

_____Non-Collision (describe) _____

Describe and Draw What Happened

Estimated Speed of Your Vehicle _____MPH. Speed of Other Vehicle_____ MPH

Multi-Car Pile Up _____ # of Cars _____ Loss of Consciousness _____?

Did You Brace For Impact? _____ Were the Brakes On? _____ Did Airbag Deploy? _____

List Any Body Part That Impacted Interior of Car _____

I Was Wearing a: Lap belt? _____ Shoulder Harness_____ or Both _____

Top of Headrest Reached _____ (neck, top of head, etc.)

Describe How You Felt Immediately After _____

Describe How You Felt That Night _____

Describe How You Felt the Next Day _____

Have You Missed Work as a Result? _____ Dates Missed _____

Are You Taking Anything For Pain _____

Have You Ever Experienced Similar Symptoms to What You are Experiencing Now?
Please Describe _____

Have You Seen Other Doctors For This Injury?

Doctor #1 _____ X-Rays Taken? _____

Doctor #2 _____ X-Ray Taken? _____

Were You Taken to the Hospital _____

Dates of Previous Auto Accidents _____

FAMILY HISTORY (list any significant diseases-diabetes, cancer..) Are you Adopted_____

Mother _____ Father _____

Grandparents _____ Aunts/Uncles/Siblings _____

Date of last Physical _____ Any Unusual Findings _____

Women: Are You Pregnant _____ How Far Along _____ Breast Implants _____

Do you Exercise Regularly_____ Types of Exercises _____

Do you smoke/use tobacco? _____ If so, how often? _____

Do you drink alcohol? _____ If so, how often? _____

Chief Complaint _____

ONSET (what were you doing when injury occurred) _____

PROVOKING (what activities aggravate your injury) Circle- Sitting / Standing / Lying / Walking / Reaching/ Bending / Other _____

PALLIATIVE (what makes it feel better) Circle- Ice / Heat / Lying / Pain Med. / Stretching / Other ___
_____

QUALITY (describe the pain) Circle- Sharp / Electric / Burning / Stabbing / Aching / Deep / Other __
_____

Any sensations radiating into the following -Circle- Arms / Legs / Forearm / Hands / Buttock / Thighs / Foot / Shoulder / Shoulder Blades / Other _____

Describe the radiating -Circle- Sharp / Dull / Tingling / Numbness / Prickling / Other _____

SEVERITY On a scale of 0 - 10 with 0 being no pain and 10 pain that prevents ALL activities _____

PATTERN (time of day most aggravated) Circle- Early Morning / Mid Day / Late Eve / After Work / After Exercise / Other _____

Complaint #2 _____

PROVOKING (what activities aggravate your injury) Circle- Sitting / Standing / Lying / Walking / Reaching/ Bending / Other _____

PALLIATIVE (what makes it feel better) Circle- Ice / Heat / Lying / Pain Med. / Stretching / Other ___
_____

QUALITY (describe the pain) Circle- Sharp / Electric / Burning / Stabbing / Aching / Deep / Other __
_____

Any sensations radiating into the following -Circle- Arms / Legs / Forearm / Hands / Buttock / Thighs / Foot / Shoulder / Shoulder Blades / Other _____

Describe the radiating -Circle- Sharp / Dull / Tingling / Numbness / Prickling / Other _____

SEVERITY On a scale of 0 - 10 with 0 being no pain and 10 pain that prevents ALL activities _____

PATTERN (time of day most aggravated) Circle- Early Morning / Mid Day / Late Eve / After Work / After Exercise / Other _____

CHECK ANY OF THE FOLLOWING YOU ARE CURRENTLY EXPERIENCING

HEAD

_____ Headache
_____ Allergies
_____ Dizziness
_____ Deafness
_____ Ringing in Ears
_____ Loss of Balance

CHEST

_____ Chest Pain
_____ Difficulty Breathing
_____ Asthma

ABDOMEN

_____ Difficult Digestion
_____ Abdominal Cramps
_____ Diarrhea
_____ Constipation
_____ Nausea
_____ Change in Urinary Function
_____ Change in Bowel Function

_____ Fainting
_____ Eye Pain
_____ Failing Vision
_____ Nosebleeds
_____ Sinus Infection

OTHER

_____ Loss of Sleep
_____ Nervousness
_____ Depression
_____ Fever
_____ Change in Menstrual Cycle
_____ Pregnant
_____ Hemorrhoids
_____ HIV+/ Aids
_____ Other _____

PLEASE CHECK ANY OF THE FOLLOWING YOU'VE HAD

_____ Alcoholism
_____ Appendectomy
_____ Cancer
_____ Diphtheria
_____ Gall Bladder Problems
_____ Heart Disease
_____ Liver Problems
_____ Multiple Sclerosis
_____ Polio
_____ Thyroid Trouble
_____ Venereal Disease

_____ Allergies
_____ Arteriosclerosis
_____ Colitis
_____ Eczema
_____ Goiter
_____ Hepatitis
_____ Malaria
_____ Pleurisy
_____ Prostate Problems
_____ Tuberculosis
_____ Whooping Cough

_____ Anemia
_____ Arthritis
_____ Diabetes
_____ Emphysema
_____ Epilepsy
_____ Kidney Stone/ Infection
_____ Migraines
_____ Pneumonia
_____ Scarlet Fever
_____ Ulcers

Signature _____ Date _____

CONSENT FORM

To Our Patients:

Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side-effects and complications is available upon request.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.

PRIVACY POLICY: Due to HIPAA Privacy Regulations, our office is required to offer you a notice of our privacy practices. This document lets you know what steps we take in protecting your health information. Please ask the front office staff if you would like a copy.

_____ Do **not** want a copy _____ Received a copy

Printed Name: _____

Signature _____ Date _____