Accident Chiropractic

1111 W. Spruce St, Suite #28 Yakima WA 98902
(509) 452-1111

PATIENT INFORMATION

Today's Date_____
Name:_____
Address:_____
City:_____State:_____Zip:_____
Sex: M F Age: _____Birthdate:_____
Cell #:_____Work#_____
Email:_____
SS#_____

Family Dr. Name:_____
Family Dr. Phone #: _____

Where did you hear from us?
_____

Radio:_____
T.V.:_____

WORK INFORMATION

Claim #: _____
Occupation:_____
Employer: _____
Employer Phone: _____
Employer Address:_____

Claim Manager _____
Claim Manager Phone #
_____

Health Insurance
Name_____
ID #_____
Phone #_____

Check if you would like to be notified of your next Appointment by either text_____or email_____

ACCIDENT INFORMATION

Is this condition due to an accident? ○Yes ○No

Date of accident_____
Place:_____

Did you hit your head? ○ yes ○ no

Did you lose consciousness? ○ yes ○ no

Did you go to the hospital? ○ yes ○ no
Which hospital?_____

When did you go? ○Immediately ○Other_____
Did you go by ambulance? ○ yes ○ no

Were X-rays taken? ○ yes ○ no
Medications given? ○ yes ○ no

Have you worked since the accident? ○ yes ○ no

Have you had any prior accidents? ○ yes ○ no
Describe_____
_____

Does it interfere with your:
○Work ○Sleep ○Recreation ○Daily Activities
Other:_____

Movements that are painful
○Sitting ○Standing ○Bending ○Walking ○Twisting ○Laying Down
Other:_____

Have you had any of the following since the accident?

○ Shoulder	○Chest Pain	○Dizziness
○Back Pain	○Fatigue	○Anxiety
○ Back Stiffness	○Hard to Sleep	○Depression
○Neck Pain	○Blurred Vision	○Irritability
○Neck Stiffness	○Memory Loss	
○Muscle Soreness	○Avoid Loud Sounds	
○Headaches	○Avoid Bright Light	
○Arm/Hand Numb	○Arm/Hand Tingle	
○Leg/Foot Numb	○Leg/Foot Tingle	
○Knee Pain	○Wrist/Elbow	
○Leg Pain	○Hip Pain	
○Arm Pain		

What treatment have you already received for your condition? ○ Medication ○ Surgery
○ Physical Therapy ○ Chiropractic Services ○ None ○ Other:_____
Name and phone # of other doctors seen:_____
Have you had any of the following **pulmonary (lung-related)** issues?
○ Asthma/difficulty breathing ○ COPD ○ Emphysema ○Other _____ ○ None of the above
Have you had any of the following **cardiovascular (heart-related)** issues?
○ Heart attacks/MIs ○ Heart disease/problems ○ Hypertension ○ Pacemaker ○ Other _____
Have you had any of the following **neurological (nerve-related)** issues?
○ Visual changes/loss of vision ○ One-sided weakness of face or body ○ Seizures ○ Headaches
○ Memory loss ○ Tremors ○ Vertigo ○ Strokes/TIAs ○ Other_____
Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
○ Thyroid disease ○ Hormone Replacement Therapy ○ Diabetes ○ Other _____
Have you had any of the following **renal (kidney-related)** issues or procedures?
○ Blood in Urine ○ Incontinence (can't control) ○ Bladder Infections ○ Other _____
Have you had any of the following **gastroenterological (stomach-related)** issues?
○ Nausea ○ Difficulty Swallowing ○ Ulcers ○ Frequent Abdominal Pain ○ Hiatal Hernia ○ Constipation
○ Liver Disease ○ Bloody Stools ○ Vomiting Blood ○ Bowel Incontinence ○ Other _____
Have you had any of the following **hematological (blood related)** issues?
○ Anemia ○ Regular Anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) ○ HIV Positive
○ Hemophilia ○ Anticoagulant Therapy ○ History of Blood Clots ○ Other _____
Have you had any of the following **dermatological (skin-related)** issues?
○ Significant Burns ○ Significant Rashes ○ Skin Grafts ○ Psoriatic Disorders ○ Other _____
Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
○ Arthritis ○ Gout ○ Spinal Fracture ○ Spinal Surgery ○ Scoliosis ○ Metal Implants ○ Other _____
Have you had any of the following **psychological** issues?
○ Psychiatric Diagnosis ○ Depression ○ Bipolar Disorder ○ Schizophrenia ○ Other_____

Family History

○ Stroke / TIAs
○ Migrane Headaches
○ Diabetes
○ Osteoporosis
○ Other _____
○ Cancer
○ Cardiac Disease
○ Arthritis
○ Neurological Disease
○ Bleeding Disorders

Social History

Job Description:_____
Recreational Activities:
_____
_____

Exercise

○ None
○ Moderate
○ Daily
○ Heavy

Work Level

○ Sitting
○ Standing
○ Light Labor
○ Heavy Labor

Habits

○ Smoking
○ Alcohol
○ Coffee/Caffeine
○ High Stress

Are you pregnant? ○ Yes ○ No Due Date: _____

Previous Surgery: ○ Back ○ Neck ○ Heart ○ Other:_____

Medications: _____

Sign: _____ Date: _____