Accident Chiropractic
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PATIENT INFORMATION

Today's Date_____
Name:_____
Address:_____
City:_____State:_____Zip:_____
Sex: M F Age: _____Birthdate:_____
Cell #:_____Work#_____
Email:_____
SS#_____
Occup. & Employer:_____
Family Dr. Name & # _____
_____
Where did you hear from us?
_____
Radio:_____
T.V.:_____

INSURANCE INFORMATION

Driver of Vehicle you were in:_____
Driver's Insurance Policy:_____
Driver's Policy #?_____
Driver's Claim #?_____
Other Vehicles Insurance:_____
Claim#:_____

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:_____
Where you the ○ driver ○ front passenger
○ rear passenger ○ pedestrian

Hit from ○ rear ○ front ○ driver side ○ passenger side
How many people were in the vehicle?_____
Were you wearing a seatbelt? ○ yes ○ no
Did an airbag deploy? ○ yes ○ no
Did any part of your body strike anything in the vehicle? ○ yes ○ no what?_____
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	○Arm Pain
○Leg/Foot Numb	○Leg/Foot Tingle	○Leg Pain
○Knee Pain	○Hip Pain	○Wrist/Elbow

Your Attorney Name & Phone_____
_____
Do you or someone in your house own a a car?
○ yes ○ no
Your Auto Insurance Company:_____
Your Policy #_____
Your Claim #_____

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

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

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: _____