PERSONAL INJURY ACCIDENT INFORMATION

Patient Name: _____

1. **Date of Accident:** _____ **Time:** _____ **AM or PM**
2. Were you: Driver _____ Passenger _____ Front Seat: _____ Back Seat: _____
3. Number of people in your vehicle _____ other vehicle: _____
4. What direction were you going? North _____ South _____ East _____ West _____
   Name of Street: _____ City _____
5. What direction was the other vehicle going? North _____ South _____ East _____ West _____
6. Were you struck from: Behind _____ Front _____ Left side _____ Right side _____
7. Were you knocked unconscious? Yes _____ No _____ If YES, how long _____
8. Were the police notified? Yes _____ No _____
9. Was anyone ticketed? Yes _____ No _____ If YES, was it you? _____
10. **In your words, please describe the accident:** _____
    _____
11. **Please describe how you felt:** _____
    A. During the accident: _____
    B. Immediately after the accident: _____
    C. Later that day: _____
    D. The next day: _____
12. **What are your present complaints and symptoms?** _____
    _____
13. **Where were you taken after the accident?** _____
14. **Have you been treated by another Doctor since the accident?** Yes _____ No _____
    If YES, please list the Doctor's name and address: _____
    _____
    What type of treatment did you receive? _____
    _____
15. **As a result of this accident, have you lost time from work?** Yes _____ No _____
    If YES, please complete the following: Date last worked: _____
    Type of work to you perform: _____
16. **Do you notice any activity restrictions because of this injury?** Yes _____ No _____
    If yes, please explain/ list restrictions _____
    _____
    _____

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PATIENT APPLICATION FOR TREATMENT

TODAY'S DATE: _____ How were you referred to the clinic? _____

NAME: _____ HOW WOULD YOU LIKE TO BE ADDRESSED? _____

YOUR ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ SS #: _____ HOME #: _____

YOUR OCCUPATION: _____ WK #: _____

EMERGENCY CONTACT: _____ PH #: _____ CELL #: _____

Date of Birth: _____ Age: _____ Gender: _____ E-mail: _____

MARITIAL STATUS S M W D Height: _____ Weight: _____ lbs

HOW MANY CHILDREN DO YOU HAVE? _____ WHAT ARE THEIR AGES? _____

THE PURPOSE OR REASON FOR THIS APPOINTMENT? _____

HOW OFTEN DO YOU DRINK ALCOHOLIC BEVERAGES? _____

DO YOU SMOKE? ❑ Yes ❑ No HOW MUCH? _____

DO YOU EXERCISE? ❑ Yes ❑ No HOW OFTEN? _____ TYPE? _____

DO YOU HAVE ANY ALLERGIES? (SPECIFY): _____

HAVE YOU EVER SUFFERED FROM OR BEEN DIAGNOSED AS HAVING: (CIRCLE YES OR NO FOR EACH)

Y	N	*Broken or Fractured Bones	Y	N	*Osteoarthritis	Y	N	Eating Disorder
Y	N	Circulatory Problems	Y	N	Epilepsy	Y	N	Alcoholism
Y	N	*Rheumatoid Arthritis	Y	N	Pacemaker	Y	N	Drug Addiction
Y	N	Seizures/Convulsions	Y	N	Strokes	Y	N	HIV Positive
Y	N	A Congenital Disease	Y	N	*Cancer	Y	N	Gall Bladder
Y	N	Excessive Bleeding	Y	N	Ulcers	Y	N	*Head Problems
Y	N	High/Low Blood Pressure	Y	N	Ruptures	Y	N	Depression
Y	N	*Diabetes	Y	N	Coughing Blood	Y	N	Tumors

* Explanation: _____

_____

_____

_____

WHEN WAS YOUR LAST PHYSICAL EXAM? _____

WHEN WAS THE LAST TIME YOU WERE INVOLVED IN AN ACCIDENT OF ANY KIND? _____

FOR DOCTOR'S USE ONLY

❑ GENERAL

INJURY TYPE:

❑ NDRA

DRUG ALLERGIES:

❑ SEE MEDS ADDENDUM

MEDICATION LIST

NAMES OF MEDICATION	NAMES OF VITAMINS	NON-Rx STRENGTH	Rx STRENGTH	DATE STARTED	DATE STOPPED	WHO PRESCRIBED DR. / SELF	
						D	S
						D	S
						D	S
						D	S
						D	S

DATE: _____

ACCT: _____

PATIENT: _____

SYSTEMS REVIEW

In the left-hand column, please indicate with a (C) Conditions you have now or with a (P) the conditions you have had in the Past. If neither apply, mark (NA), don't leave any blanks.

High Blood Pressure ____
Dizziness/Fainting ____
Insomnia ____
Low Resistance ____
Tension ____
Confusion ____
Fatigue ____
Ulcers ____
Eye/Vision Problems ____
Ear/Hearing Problems ____
Difficulty Breathing ____
Heart Problems ____
Loss of Bladder Control ____
Constipation ____
Diarrhea ____
Digestion Problems ____
Nausea ____
Female Problems ____
Prostate Problems ____
Diabetes ____
Hands/Feet Cold ____
Hand Tremors ____
Loss of Memory ____
Nervousness ____
Sweaty Palms ____
Speech Difficulty ____
Anxiety ____
Depression ____
Irritablility ____

FOR DOCTORS'S USE ONLY

DR. REVIEWED	SYSTEMS	SYMPTOMS
_____	General	Weight changes, fatigue, anorexia, weakness, fever, chills changes in activity
_____	Skin	Rashes, eruptions, changes in warts or moles, pigmentation changes, bruising, itching, hair loss, nail changes
_____	Head	Trauma, headaches, dizziness, light headed
_____	Eyes	Change in acuity of vision, use of corrective lensed, loss of diplopia, photophobia, blurred vision, scotomata, pain, excessive lacrimation, redness, discharge
_____	Nose	Rhinorrhea, epistaxis, allergies, airway obstruction
_____	Mouth & Throat	Ulcers, tooth pain/extractions, temporomandibular joint (TMJ), pain, gum bleeding, soreness, swelling, enlarged glands, sore throat, strep throat
_____	Neck	Stiffness, lumps/swelling/masses, pain
_____	Lungs	Cough (productive/nonproductive), hemoptysis, dyspnea, pain with respiration, wheezing, night sweats
_____	Cardiac	Palpitations, chest pain, orthopnea, paroxysmal nocturnal dyspnea, ankle swelling, syncope
_____	Vascular	Raynaud's phenomenon, intermittent claudication, hypertension, rheumatic fever
_____	Breasts	Self-examination frequency/results, pain, nipple discharge, lumps/masses, skin dimpling
_____	Gastrointestinal	Unusal diet, sysphagia, regurgitation, dyspepsia, nausia, vomiting, belching, abdominal pain, cramps, hematemasis, stool color changes, diarrhea, sonstipation, change in bowel habits, jaundice, abdominal swelling
_____	Genitournary	Polyuria, nocturia, oliguria, dysuria, uregency, incontinence, urine color changes, hematurea, sexually transmitted diseases, dyspareunia, scrotal mass (male), hernia
_____	Endocrine	Polydipsia, polyphagia, temperature intolerance, tremors, goiter, alopecia, hirsutism, menstration, history, pregnancy history, dysmenorrhea, premenstrual syndrome, climacteric
_____	Hematopoietic	Anemia, abdominal bleeding, lymph node elargement/pain
_____	Musculoskelatal	Bone/Joint pain, swelling, joint deformity, trauma, restricted range of motion, weakness, atrophy
_____	Neurological	Cranial nerve deficits, seizures, loss of consciousness, paralysis, tremors, staxis, loss of balance, numbness, paresthesia
_____	Psychological	Mood swings, depression, anxiety, phobias

Please identify all facilities/providers you have seen for these conditions and those you are currently seeing, if any, for your presenting problem(s)

PROBLEM LIST

DR NAME/ FACILITY	PROBLEM	TYPE OF TREATMENT RECIEVED	FROM WHEN TO WHEN

FOR DOCTORS USE ONLY

☐ Reviewed External H P
☐ Release Records H P
☐ Request Records H P

EXTERNAL DX'D: _____

DISABILITIES:

IMPAIRMENTS:

DATE: _____

ACCT: _____

PATIENT: _____

PATIENT HISTORY

1. What is your **main complaint?** _____
2. On the scale below, please **circle** the **severity** of your **main complaint** (At it's worst)

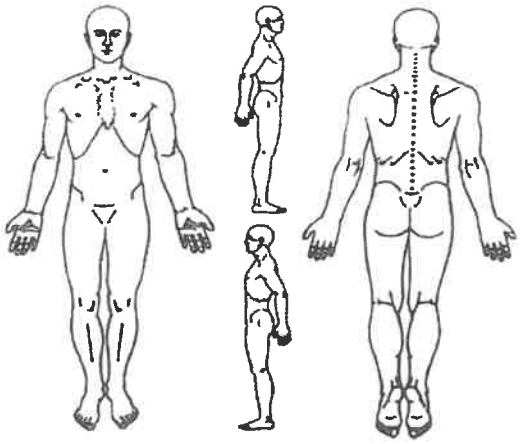
None		*Slight*		*Mild*		*Moderate*			*Severe*
1	2	3	4	5	6	7	8	9	10

3. On the scale below please **circle** the **percentage of time** you experience your **main complaint:**

	Occasional			*Intermittent*			*Frequent*			*Constant*	
0	10	20	30	40	50	60	70	80	90	100	%

4. How **long** have you been experiencing your **main complaint?** _____
5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ache **B:** burning pain **C:** cramping **D:** dull pain **R:** throbbing pain **N:** numbness **T:** tingling



Do you have **pain** and/or difficulty performing any of the following activities: (Check)

personal care	____
lifting	____
reading	____
concentrating	____
work	____
driving	____
sleeping	____
recreation	____
walking	____
sitting	____
standing	____
social life	____

6. When do you notice it most? ❑ AM ❑ PM
   How long does it last? _____Mins _____Hrs
7. What makes it feel better? _____
8. What makes it feel worse? _____
9. Have you ever had this problem in the past? ❑ Yes ❑ No
10. I have ❑ been hospitalized ❑ been treated by another chiropractor ❑ been treated by another specialty provider ❑ never received care for this problem.
11. Have you lost time from work because of it? ❑ Yes ❑ No
    Dates?_____ to _____
12. Are you Pregnant? ❑ Yes ❑ No
13. What was the first day of your last menstrual cycle? _____
14. Number of pregnancies? _____ Miscarriages? _____

Signature: _____

Date: ___/___/___