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Please Print

Patient Information

Name ____ Date ______________
Date of Birth ___________Age__________Social Security #______________________
E-Mail Address ____
Street Address ____
City ___________________________ State ____________________ Zip __________
Home Phone _________________________ Cell Phone ___________________________
Occupation____
Employer ______________________________ Business Phone ____________________
Sex: □ Male □ Female Height______ Weight _______ □ Right handed □ Left Handed
Are you: □ Married □ Single □ Domestic Partnership □ Divorced □ Separated □ Widowed
Spouses Name: _________________________ # of Children______________________
Emergency Contact Name _________________________ Relationship_______________
Emergency Contact Phone ____
Name of Person Responsible for payment:_______________________________________
Your Insurance Carrier___________________________ Claim Number _____________
Your Health Insurance____________________________ Policy Number_____________
Other Party's Insurance Carrier ____________________ Claim Number _____________
Work Comp Insurer_______________________________ Policy Number_____________
Name of Policyholder, if other than you______________________________________
Other Insurance__________________________________ Policy Number_____________
Name of Your Attorney____________________________ Phone Number _____________
Date of Incident____________ Were you taken to Emergency Room? Y-N Ambulance Y-N

<u>Please Provide Insurance Card To Be Copied</u>

How did you hear about us?____

Signatures

Name of the Insured____

I understand and agree that health/accident insurance policies are an arrangement between and insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature____**Date**_______________

Spouses's or guardian's signature__________________________**Date**________________

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Present Health

What are your health concerns? ____
____
What are your goals coming in today? ____
____
Who is your primary care provider? ____
Address ____
Phone ____
Please list any allergies you may have ____
____
Please list any medications you are currently taking ___________________________________
Please list any supplements you are currently taking ___________________________________
Please list any other physicians you have seen as a result of this incident:
____
Describe your current exercise regimen ____
____
Did you strike your head or any other part of your body in this accident? ___________________
____

Medical History

Have you ever been treated by a:
- □ Chiropractor
- □ Naturopathic Doctor
- □ Reflexologist
- □ Massage Therapist
- □ Acupuncturist
- □ Other alternative practitioner

Family History

Check applicable	Father	Mother	Grandparent	Sibling	Other (Specify)
Anemia	______	______	______	______	________
Cancer	______	______	______	______	________
Diabetes	______	______	______	______	________
Heart Disease	______	______	______	______	________
High Blood Pressure	______	______	______	______	________
Stroke	______	______	______	______	________
Epilepsy	______	______	______	______	________
Psychological Disorder	______	______	______	______	________
Asthma	______	______	______	______	________
Hay fever, Hives	______	______	______	______	________
Kidney Disease	______	______	______	______	________
Glaucoma	______	______	______	______	________
Tuberculosis	______	______	______	______	________
Age at death	______	______	______	______	________
General Health *(G=Good, P=Poor)*	______	______	______	______	________

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Personal History

As a child, did you have any of the following diseases?
□ Scarlet fever □ Rheumatic fever □ Diphtheria □ Mumps □ Measles □ German measles
□ Other ____
List hospitalizations or surgeries have you had with corresponding dates
____
Have you ever been in an auto accident? _________ When? ______________________________
List other injuries including falls and other traumas and when they occurred:
____
Have you been diagnosed with any diseases or disorders and when? ______________________
____
List childhood immunizations you received ____
Last Tetanus shot____

Review of Symptoms

Weight _______ Weight 1 yr. ago _______ Max. Weight ______ When ______

Please Circle the appropriate letter next to each item based on the following:

Y= a condition you have now **P**= a condition you have had in past **N**= never had

Neck Pain	Y P N	Tearing/Dryness	Y P N
Back Pain	Y P N	Double Vision	Y P N
Lower Back Pain	Y P N	Pallectomy	Y P N
Extremity Pain	Y P N	Cataracts	Y P N
Chest Pain	Y P N	Impaired Hearing	Y P N
Right/Left Arm Pain/ Tingling	Y P N	Ear Ringing	Y P N
Right/Left Leg Pain/Tingling	Y P N	Earaches	Y P N
Right/Left Foot Pain/Tingling	Y P N	Frequent Colds	Y P N
Right/Left Hand Pain/Tingling	Y P N	Sinusitis	Y P N
Fingers/Toes Pain/Tingling	Y P N	Postnasal Drip	Y P N
Spasms	Y P N	Change in Taste	Y P N
Dizziness	Y P N	Goiter	Y P N
Vision Disturbance	Y P N	Cough	Y P N
Motion Restriction	Y P N	Sputum	Y P N
Radiating Symptom	Y P N	Spit up Blood	Y P N
Sleep Disruption	Y P N	Asthma	Y P N
Anxiety	Y P N	Bronchitis	Y P N
Night Sweats	Y P N	Pneumonia	Y P N
Headaches	Y P N	Emphysema	Y P N
Head Injury	Y P N	Difficulty Breathing	Y P N
Impaired Vision	Y P N	Shortness of Breath	Y P N
Corrected Vision	Y P N	Heart Disease	Y P N
Depression	Y P N	Angina	Y P N

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High Blood Pressure Y P N
Fasciotomy Y P N
Edema Y P N
Arthroplasty (prosthetic replacement)
Y P N
Nausea Y P N
Vomiting Y P N
Constipation Y P N
Blood in Stool Y P N
Gas/Bloating Y P N
Liver Disease Y P N
Hemorrhoids Y P N
Abdominal Pain Y P N
Peptic Ulcer Y P N
Gall Bladder Disease Y P N
Pain on Urination Y P N
Urinary Frequency Y P N
Ligament or Tendon repair, not arthroscopy, Arthrotomy Y P N
Kidney Stones Y P N
Blood in Urine Y P
N
Joint Pain/Stiffness Y P N
Arthritis Y P N
Broken Bones Y P N
Muscle Spasms Y P N
Deep Leg Pain Y P N
Thrombophlebitis Y P N
Aspiration of Hematoma Y P N
Fainting Y P N
Seizures Y P N
Paralysis Y P N
Muscle Weakness Y P N
Numbness/Tingling Y P N
Coordination Difficulties Y P N
Depression Y P N
Anxiety Y P N
Mood Swings Y P N
Memory Loss Y P N
Drug/Alcohol Abuse Y P N
Difficulty Sleeping Y P N

Phobia Y P N
Thyroid Problem Y P N
Extremity Pain – Numbness Y P N

Arthrotomy, Meniscectomy, cruciate
Y P N
Excessive Thirst Y P N
Excessive Hunger Y P N
Anemia Y P N
Easy Bleeding Y P N

Females Only

Age menses began ___________
Age menses ended ___________
Average cycle length ___________
Average bleeding length ___________
Spotting Y P N
Irregular Cycles Y P N
Painful Menses Y P N
Birth Control Y P N
Sexual Difficulties Y P N
STD Y P N
Breast Lumps Y P N
Breast Pain Y P N
Nipple Discharge Y P N
PMS Symptoms Y P N
Menopausal Symptoms Y P N
Vaginal Dryness Y P N
Vaginal Discharge/Sores Y P N
Number of pregnancies __________
Number of live births __________
Number of miscarriages __________

Male Only

Hernias Y P N
Testicular Masses Y P N
Testicular Pain Y P N
Sexual Difficulties Y P N
STD Y P N
Penile Discharge/Sores Y P N
Prostate Disease Y P N

Are there any additional health concerns or questions you have?

____
____
____
____
____

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Describe the Incident

____

____

____

____

____

____

____

____

Please provide us with a copy of police report.

What speed was the car you were in going? ______mph

What speed was the car that hit your car going? ______mph

Where in the car were you seated? **Front** – Driver/Psgr **Rear** – Driver/Psgr

Were you wearing seatbelts? Y-N

Where was the car you were in struck? **Rear** **Front** **Side**

What was the amount of property damage? $________________

Patient:________________________ Signature______________________Date:_____

Use the pictures below to indicate your problem areas. Use the appropriate symbol to indicate numbness, pins & needles, burning, stiffness, aching, or stabbing pain.

Numbness: □

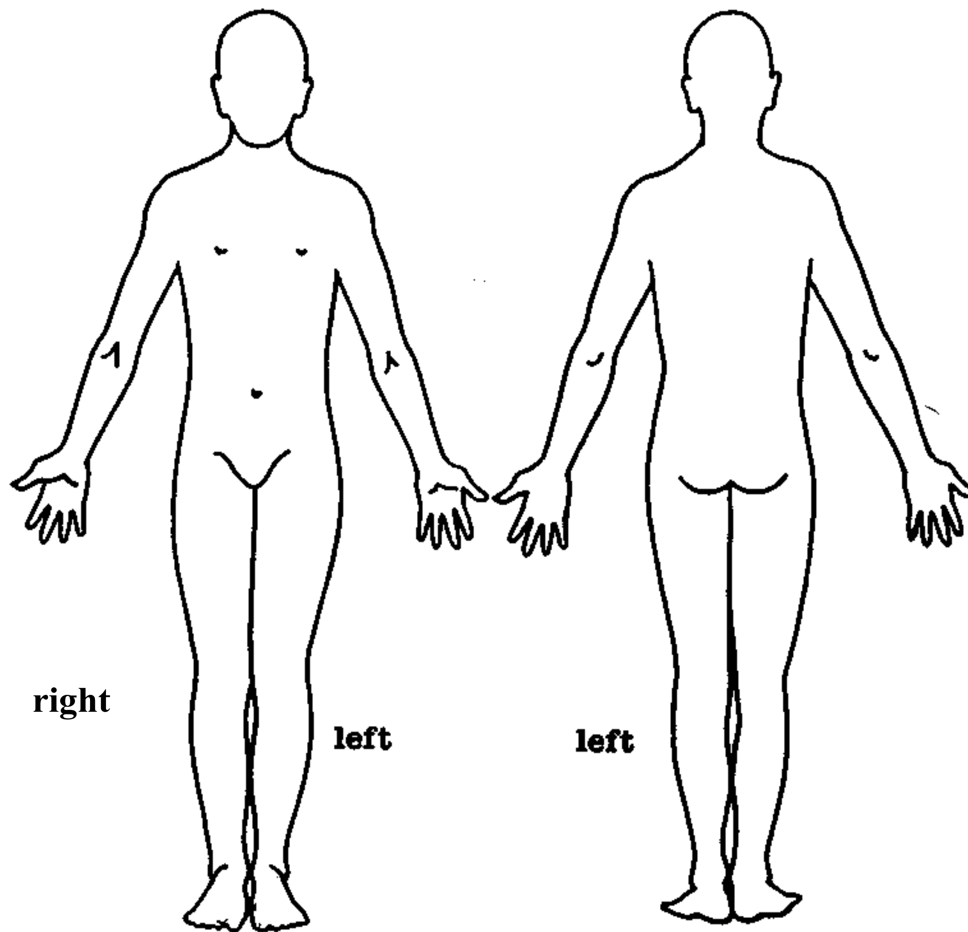
Pins & Needles: .-.

Burning: #

Aching pain: ±

Stiffness: u

Stabbing pain:



Please rate your discomfort on a scale of 1-10.
(1= mild pain, 10=the worse pain you've ever felt).

	Location	Pain rating
1.	______________________	______________________
2.	______________________	______________________

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3. ______________________________ ______________________________

Patient:__________________________**Signature**__________________________**Date**_______

DUTIES UNDER DURESS

Are there day to day living duties which are painful or difficult for you to perform as a result of the injuries you sustained in the motor vehicle collision?

Include those duties/responsibilities which require that you reduce the time you are capable of performing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your performance.

Work Reason for the difficulty Duration
(Performance while experiencing any symptom would be an acceptable reason)

____

Studies/School Reason for the difficulty Duration
(Performance while experiencing any symptom would be an acceptable reason)

____

Domestic Duties

Examples (List all)	Reason for the difficulty	Duration
Vacuuming		
Taking care of children		
Dishes/Dusting/Laundry		
Preparing meals		
Other domestic responsibilities		

(Performance while experiencing any symptom would be an acceptable reason)

____

Household Duties

Examples (List all)	Reason for the difficulty	Duration
Mowing/Yard work		
Transporting family		
Shopping		
Taking out trash		
Other outside responsibilities		

(Performance while experiencing any symptom would be an acceptable reason)

____

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Patient:____________________________**Signature**____________________________**Date**_______

LOSS OF ENJOYMENT

Are there areas of your life which you normally would be performing, but are currently not as a result of the motor vehicle collision?

Include all areas which you have had to reduce the time you are capable of performing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your performance in any of the following areas.

Work Reason for the inability to perform Duration
(Reduction of participation or time associated with this activity while experiencing any symptom would be an acceptable reason)

Studies/School Reason for the difficulty Duration
(Reduction of participation or time associated with this activity while experiencing any symptom would be an acceptable reason)

Hobbies of any kind (example: card playing, jogging, knitting, dancing, socializing, entertainment, vacations, etc. DO NOT INCLUDE SPORTS)

(Reduction of participation or time associated with this activity while experiencing any symptom would be an acceptable reason)

Domestic Duties

Examples (List all)	Reason for the inability to perform	Duration
Vacuuming		
Picking up the children		
Dusting		
Making dinner		
Other domestic responsibilities		

(Reduction of participation or time associated with this activity while experiencing any symptom would be an acceptable reason)

Household Duties

Examples (List all)	Reason for the inability to perform	Duration
Mowing/Yard work		
Transporting family		
Shopping		
Taking out trash		
Other outside responsibilities		

(Reduction of participation or time associated with this activity while experiencing any symptom would be an acceptable reason)

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