

WELCOME TO OUR OFFICE

PLEASE PRINT

Full Name _____ Nickname _____ Date _____
Address _____ Apt # _____ Age _____ Date of Birth ____/____/____
City, State _____ Zip _____ email _____ Driver's Lic # _____
Home Ph# _____ Work Ph# _____ Cell Ph# _____
Marital Status: Married Single Widowed Divorced Separated Number of Children _____
Employer _____ Employers Address _____
Years Employed _____ Job Title _____ Type of Work _____
Spouse's Name _____ Spouse's Employer _____
Name of Insurance Company _____ Phone# _____ Are
you insured through your spouse or parent? Yes No If yes, what is their Name _____
Social Security # _____ Date of Birth ____/____/____ Employer _____
How will payment be made? Cash Check Credit Card Workers' Comp Health Ins. Medicare Auto Ins. Lien
Who is your Primary Care Physician? _____ Phone: _____
Address _____ Fax: _____

To help your first visit go smoothly here is what you can expect during approximately the next 45-75 minutes:

- 1. Paperwork** Give your forms to the receptionist when you have completed them. The doctor will use this information to learn about your present health status. **If this visit is regarding an auto accident, a work injury or managed care please let us know, additional forms may be required.** Also take a moment to review and sign our financial policy.
- 2. Consultation** You will meet the doctor, who will review your paperwork and discuss your health history and your present complaint. You will be advised of the cost of any office procedure.
- 3. Examination** A complete examination, including any necessary X-rays, will be performed. Afterwards the doctor will review the results and determine if Chiropractic can help you. When appropriate, you will be referred to other health care professionals.
- 4. Initial Treatment** If you are currently in pain, initial pain relief treatment will begin on your first visit. This may consist of any of the following

Chiropractic Adjustment - The doctor will use a carefully directed and controlled pressure to begin restoring normal motion and position to the moveable bones of your spine. You may feel or hear a slight pop or snap, which is due to joint movement.

Additional Therapy Procedures such as heat, ice, traction, electrical therapy, ultrasound, and diathermy. These procedures are helpful to reduce the pain, spasm, inflammation, or stiffness you may have.
- 5. Home Therapy** The doctor may suggest home use of ice, heat, or stretching exercises, nutritional supplements, and orthopedic supports to reduce your discomfort.
- 6. Future Visits** On your next visit plan to spend 30 - 45 minutes to receive the doctor's report of findings and additional treatment. You are always welcome to bring any family members or friends along so they can learn about your condition.

We hope this information will help to make your first visit more pleasant. If you have any questions don't hesitate to ask. If you were referred by one of our patients let them know we appreciate it.
After you have read this form please initial here. _____

PATIENT HISTORY PERSONAL INJURY

Name _____

Date _____

Place the letters on the figure below to indicate the type and location of your present sensations.

- | | | |
|---------------------------|---------------------|---------------------|
| A = ache | B = burning | N = numbness |
| P = Pins & needles | S = stabbing | O = other |

Please place a mark on the line below indicating your present level of pain.

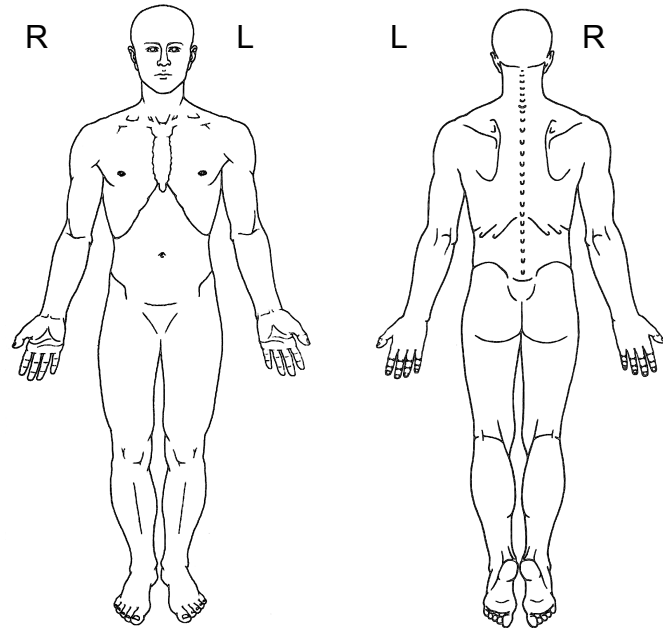


No Pain Worst Pain
Imaginable

How often are your complaints present :

- 0-25%** **26-50%** **51-75%** **76-100%**

Please describe your major complaint with regards to the **type of pain**. For example: dull, sharp, soreness, stiffness, throbbing, shooting, burning, spasm, weakness, tingling.



Date of Injury: _____ Time _____

Please describe the injury or collision in your own words: _____

Please describe how you felt:

Immediately after the injury _____

Were you: Dazed Dizzy Unconscious In Shock Shaky Light-headed Nervous Stunned Confused Nauseated

How did you feel later that day? _____

How did you feel the next day? _____

How did you feel a week later? _____

Since this injury occurred, are your symptoms? improving getting worse staying the same
 Has the condition altered your ability to sleep? yes no If yes, describe _____

Has the condition altered your ability to interact with family/friends? yes no If yes, describe _____

Has the condition altered your ability to care for yourself? yes no If yes, describe _____

Has the condition altered your ability function at work? yes no If yes, describe _____

Have you taken time off work as a result of this injury? yes no If yes, when did you last work? _____

If you are working now, are you in discomfort? yes no If yes, describe: _____

Doctor Notes:

What was your position in the car? driver front passenger rear seat L R Middle 3rd row seat L R Middle other: _____

How many people were in the car including yourself? _____

What were the road conditions? dry wet icy Weather conditions? clear fog rain snow glare

Were you wearing a seat belt? yes no If yes, what type? lap only lap & shoulder

Did your seat have a? movable headrest non-movable head rest no headrest don't remember
How was your headrest positioned: at the top of the back of your head middle of back of head bottom of back of head at your neck

Is your car equipped with? ABS airbags If you have airbags did they inflate? yes no Were you injured by the airbags? yes no

Make, model and year of your vehicle? _____ Other Vehicle? _____

What is the estimated damage to your vehicle? _____ To other vehicle? _____

POINT OF IMPACT

Was the impact a? single car crash two vehicle crash three or more ran off road hit guardrail/tree other

rear-ended head on crash sideswipe L R T-bone L R struck another car from behind

Your vehicle's speed at impact? ____ mph Was it? stopped slowing down speeding up maintaining speed

Other vehicle's speed at impact? ____ mph Was it? stopped slowing down speeding up maintaining speed

Did your vehicle strike another vehicle? yes no Did your vehicle strike anything else? Describe _____

Did the impact cause your car to? Move forward hitting nothing move forward, hitting car in front roll over
Spin around hitting nothing spin around hitting another car spin around hitting another object

Did you hear anything to warn you of the impact? yes no

At impact were you? unaware of impact neck and body facing forward aware of impending impact & relaxed neck and or body turned to L R aware & braced for impact looking in rear view mirror

Were both hands on the steering wheel? yes no If no, then which hand? left right neither

Was your foot on the brake? yes no If yes, which foot? left right both

During the collision did your body move? forward and back sideways thrown from seat thrown from vehicle

Indicate if your body hit or was hit by any of the following:

Please draw lines and match the left side to the right side.

Head	Headrest
Face	Windshield
Shoulder	Steering wheel
Neck	Side door
Chest	Dashboard
Hip	Car frame
Knee	Another occupant
Foot	Seat
	Seat belt

Check if any of the following vehicle parts broke, bent, or were damaged in your car

<input type="checkbox"/> Windshield	<input type="checkbox"/> Seat frame	<input type="checkbox"/> Knee bolster
<input type="checkbox"/> Steering wheel	<input type="checkbox"/> Side/rear window	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Dash	<input type="checkbox"/> Mirror	<input type="checkbox"/> Other: _____

Did anything strike you in the car? yes no If yes, what? _____

Doctor Notes:

AFTER THE COLLISION

After the collision were you? conscious dazed unconscious able to walk out of car unable to get out of car

Did you have any? cuts or lacerations stitches bumps or bruises If yes have you taken pictures of them? yes no

Did you go to the hospital? yes no If yes, did you go immediately next day other: _____

What hospital? _____ Did you get there by? ambulance your vehicle other vehicle

Were X-rays taken? yes no Were you treated at the hospital? yes no Were you given medications? yes no

Have you received any other treatment for this injury? yes no If yes by who? _____ Address: _____

Have you tried any of the following self treatment since the injury ?

I self-treated with over-the-counter drugs I took hot showers, used ice, heat Other _____

PLEASE CHECK OFF ALL PAST OR PRESENT SYMPTOMS

<p>past present HEAD</p> <p><input type="checkbox"/> <input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> <input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> <input type="checkbox"/> Tension</p> <p><input type="checkbox"/> <input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> <input type="checkbox"/> Tired, Fatigue</p> <p><input type="checkbox"/> <input type="checkbox"/> Head feels heavy</p> <p><input type="checkbox"/> <input type="checkbox"/> Light bothers eyes</p> <p><input type="checkbox"/> <input type="checkbox"/> Loss of taste or smell</p> <p>NECK</p> <p><input type="checkbox"/> <input type="checkbox"/> Neck pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Neck stiffness</p> <p><input type="checkbox"/> <input type="checkbox"/> Neck spasms</p> <p><input type="checkbox"/> <input type="checkbox"/> Popping in neck</p> <p>SHOULDER</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain in shoulder jt.</p> <p><input type="checkbox"/> <input type="checkbox"/> Tension in shoulders</p> <p>ARM&HAND</p> <p><input type="checkbox"/> <input type="checkbox"/> Arm pain (R-L)</p> <p><input type="checkbox"/> <input type="checkbox"/> Arm numbness (R-L)</p> <p><input type="checkbox"/> <input type="checkbox"/> Wrist/hand pain (R-L)</p> <p><input type="checkbox"/> <input type="checkbox"/> Weak grip (R-L)</p> <p><input type="checkbox"/> <input type="checkbox"/> Elbow pain (R-L)</p> <p><input type="checkbox"/> <input type="checkbox"/> Cold hands</p>	<p>past present MID-BACK</p> <p><input type="checkbox"/> <input type="checkbox"/> Upper back pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain between shlders</p> <p><input type="checkbox"/> <input type="checkbox"/> Rib pain</p> <p>CHEST</p> <p><input type="checkbox"/> <input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> <input type="checkbox"/> Breast pain</p> <p>ABDOMEN</p> <p><input type="checkbox"/> <input type="checkbox"/> Heartburn</p> <p><input type="checkbox"/> <input type="checkbox"/> Stomach cramps</p> <p><input type="checkbox"/> <input type="checkbox"/> Nervous stomach</p> <p><input type="checkbox"/> <input type="checkbox"/> Food allergies _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Gas</p> <p><input type="checkbox"/> <input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> <input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> <input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> <input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood in stool</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis</p> <p>FAMILY HISTORY</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis</p>	<p>past present LOWER BACK</p> <p><input type="checkbox"/> <input type="checkbox"/> Lower back pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Buttock pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Muscle spasms</p> <p><input type="checkbox"/> <input type="checkbox"/> Lower back stiffness</p> <p><input type="checkbox"/> <input type="checkbox"/> Back feels tired</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain increased by coughing</p> <p>HIP, LEG&FOOT</p> <p><input type="checkbox"/> <input type="checkbox"/> Hip pain (R-L)</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain in leg (R-L)</p> <p><input type="checkbox"/> <input type="checkbox"/> Knee pain (R-L)</p> <p><input type="checkbox"/> <input type="checkbox"/> Knee gives way (R-L)</p> <p><input type="checkbox"/> <input type="checkbox"/> Leg cramps</p> <p><input type="checkbox"/> <input type="checkbox"/> Shooting pain in leg/foot (R-L)</p> <p><input type="checkbox"/> <input type="checkbox"/> Tingling in leg/foot (R-L)</p> <p><input type="checkbox"/> <input type="checkbox"/> Numbness in leg/foot (R-L)</p> <p><input type="checkbox"/> <input type="checkbox"/> Swollen ankles</p> <p><input type="checkbox"/> <input type="checkbox"/> Ankle/Foot pain (R-L)</p> <p><input type="checkbox"/> <input type="checkbox"/> Ankle sprain (R-L)</p> <p>MISC.</p> <p><input type="checkbox"/> <input type="checkbox"/> Loss of bowel or bladder control</p> <p><input type="checkbox"/> <input type="checkbox"/> Loss of memory</p> <p><input type="checkbox"/> <input type="checkbox"/> Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer</p>	<p>past present WOMEN ONLY</p> <p><input type="checkbox"/> <input type="checkbox"/> Menstrual pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Cramping</p> <p><input type="checkbox"/> <input type="checkbox"/> Irregular cycle</p> <p><input type="checkbox"/> <input type="checkbox"/> Birth control _____type</p> <p><input type="checkbox"/> <input type="checkbox"/> Hysterectomy</p> <p><input type="checkbox"/> <input type="checkbox"/> Caesarean delivery</p> <p>MEN ONLY</p> <p><input type="checkbox"/> <input type="checkbox"/> Urinary frequency</p> <p><input type="checkbox"/> <input type="checkbox"/> Difficulty starting urination</p> <p><input type="checkbox"/> <input type="checkbox"/> Painful urination</p> <p>GENERAL</p> <p><input type="checkbox"/> <input type="checkbox"/> Nervousness</p> <p><input type="checkbox"/> <input type="checkbox"/> Irritable</p> <p><input type="checkbox"/> <input type="checkbox"/> Depression</p> <p><input type="checkbox"/> <input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> <input type="checkbox"/> Loss of sleep ____hrs./night</p> <p><input type="checkbox"/> <input type="checkbox"/> Loss of weight ____lbs.</p> <p><input type="checkbox"/> <input type="checkbox"/> Gain of weight ____lbs.</p> <p><input type="checkbox"/> <input type="checkbox"/> Coffee ____cups/day Tea ____cups/day</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcohol ____ drinks per week</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain worse at night or at rest</p>
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Doctor Notes:

PAST HISTORY

Within the past 2 years have you had any auto collisions, work or sports injuries? yes no If yes, describe including date(s) and any area injured.

Did you receive treatment? _____

Just before your recent injury would you say your prior injury was?

Fully resolved Mostly resolved Resolving with treatment Resolving without treatment

Not resolved, I still experienced the following complaints: _____

Did you have any physical complaints before your current injury? yes no If yes, please describe in detail. _____

Have you had any physical complaints similar to the ones caused by this injury? yes no If yes describe them and their causes

Have you had any surgeries in the past? yes no If yes, describe. _____

Have you ever consulted a chiropractor in the past? yes no If yes, who? _____

Are you pregnant? yes no If yes, what is your due date? _____

Do you smoke? yes ___pks per day no If you quit smoking, when? _____

Are you taking any medications? yes no What kind? _____

Do you take vitamins or supplements? yes no What kind? _____

Do you exercise regularly? yes no If yes, what type and how often? _____

**Fees are payable at the time x-rays, examinations, and treatments are rendered,
unless other arrangements are made in advance.**

Patient's Signature

Date

Doctor Notes:

