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# ________________ Social Security # ______________
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 __________________________________
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 this form to the receptionist when you have completed it. 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.

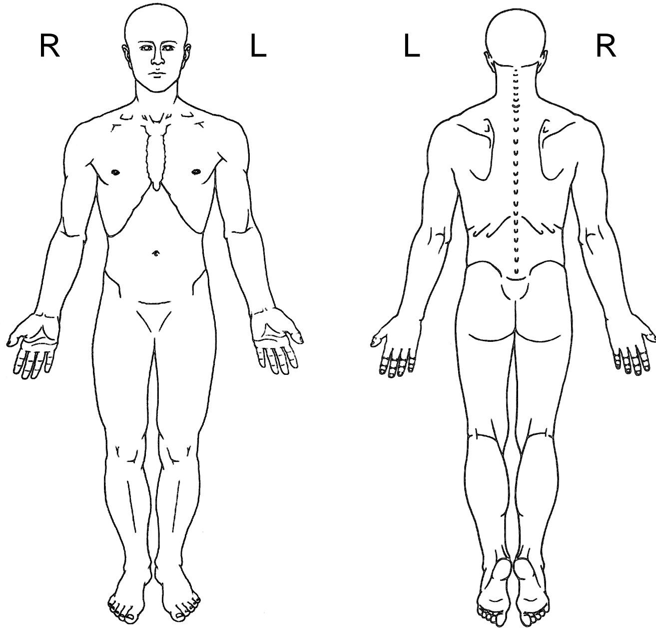
After you have read this form please initial here. _____________________ **2015_F.6_Complete PI paperwork**

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.

0 10

No Pain Worst Pain Imaginable

Online version give your pain a number on a 1-10 scale ______

How often are your complaints present :

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

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

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Date of Accident _________________________ Time__________

Please describe the accident in your own words: ____

____

Please describe how you felt: during the accident. ____

Immediately after the accident. ____

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

How did you feel later that day? ____

Were you able to sleep that night? yes no if no describe _______________________________

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 to 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 ___________________________

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Doctor's Notes

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COLLISION CONDITIONS

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? __________ Was anyone else injured? ____

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 headrest? movable headrest non movable headrest no headrest don't remember
How was your headrest positioned at top of back of 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

Model, year and make 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 sideswiped L R T-bone L R struck another car from behind

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

Was your vehicle? speeding up slowing down maintaining speed

Was the other vehicle? speeding up slowing down maintaining speed

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

Did you hear or see anything to warn you of the impact? yes no Were you able do to anything to avoid the impact? _________________

Was the impact from the? front rear left right other ____

At impact were you? unaware of impact aware of impending impact & relaxed aware & braced for impact
neck and body facing forward neck and or body turned to L R 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? back and forward 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

Windshield	Seat frame	Knee bolster
Steering wheel	Side/rear window	Other: __________
Dash	Mirror	Other: __________

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

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 or MRI 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 ___________________________________

MEDICAL LEGAL

Were the police notified ? yes* no *If yes was there a police report? yes no

Were there any witnesses? yes no Did you get their contact info? ___________________________

Were any citations issued? yes* no *If yes to whom ?______________________________

PLEASE CHECK OFF ALL PAST OR PRESENT SYMPTOMS

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

Doctor Notes:

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PAST HISTORY

Have you had any previous auto accidents, work or sports injuries before ? yes* no *If yes, describe including date(s) and any area injured.

____

Did you receive treatment? ____

____

Did you have any physical complaints before the accident? yes* no * If yes, please describe in detail. ______________________

____

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 ? ________________________________

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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:

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