Confidential Patient Data

PATIENT INFORMATION **Today's Date:_____**

Name:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

CellPhone:_____Alt.Phone:_____EmailAdress:_____

Social Security #:_____ Age:_____ ❑ Male ❑ Female
Marital Status:
❑ Married ❑Single ❑Divorced ❑Separated ❑ Other _____ Number of Children_____

Your Occupation_____ Your Employer:_____
❑ Full-Time ❑Part-Time ❑Retired ❑Student ❑Homemaker ❑ Disabled ❑Unemployed

Emergency Contact Name:_____ Relation to you:_____
Phone:_____
Referred to this Office by: ❑Friend/Family Member - Name?_____
❑Advertisement ❑ Social Media ❑Internet ❑Direct Marketing/Other_____

Name of Insurance Co.:_____Member#_____Group#_____

Insured's Name _____ Insured's Social Security #:_____Insured's DOB_____

Are you covered by more than one insurance company? ❑Yes ❑No If, Yes please list info below.

Name of Insurance Co _____ Member#_____Group#_____

The Reason for your visit: ❑Auto/Cycle Accident ❑Slip and Fall ❑Sports Injury
❑Home Injury ❑Pain ❑Other_____(Please describe)
Have you been or are currently being treated by a physician for any health condition(s)?
❑Yes ❑No Describe Condition_____
Date of Last Physical Exam_____
Are there any past conditions or illnesses you have that we should be aware of? ❑Yes ❑No
1._____ Date:_____
2._____ Date:_____
Has anyone in your family been treated for or any serious health conditions or illnesses? ❑Yes ❑No
(such as cancer, diabetes, hypertension, etc.?)
1._____ Relation:_____
2._____ Relation:_____
SURGICAL HISTORY:
1._____ Date:_____
2._____ Date:_____
Have you ever had a metal implant? ❑Yes ❑No Ever been gunshot? ❑Yes ❑No
Are you currently taking any medications? ❑Yes ❑No Are you pregnant? ❑Yes ❑No

Medication List:._____ Date of last menstrual period:_____
_____
_____
ARE YOU ALLERGIC TO ANY MEDICATIONS ❑Yes ❑No
If so WHAT KIND?_____

COMPLAINTS/SYMPTOMS

AREA OF COMPLAINT/SYMPTOM:_____
(Please list each area of complaint separately)

Approximate date of onset:_____

How did this occur?:_____

Is the pain…?(Check box that most applies)
❑ CONSTANT ❑ FREQUENT ❑ INTERMITTENT ❑ON/OFF ❑ RANDOM ❑ RECURRING

On a scale from 1-10 Please rate this complaint/symptom: **#**_____
(10 being the worst**)**

Describe your discomfort for the above listed symptom. Choose all that apply:

❑Aching	❑Deep	❑Heavy	❑Sharp	❑Throbbing
❑Annoying	❑Diffuse	❑Intolerable	❑Shock like	❑Tightness
❑Burning	❑Dull	❑Pulling	❑Stabbing	❑Tingling

Has your symptom changed since ONSET? Choose all that apply:

❑Pain has improved	❑Pain has worsened
❑Pain stayed the same	❑Symptoms have disappeared

What improves your condition? Choose all that apply:

❑Chiropractic adjustments	❑Massage	❑Prescription medication
❑Cold packs	❑Nothing	❑Rest
❑Exercise	❑Over The Counter medication	❑Stretching
❑Heat packs	❑Physical Therapy	❑Work

What aggravates your condition? Choose all that apply:

❑Almost any movement	❑Coughing/sneezing	❑Household chores	❑Running	❑Working
❑Bathing	❑Daily child or pet care	❑Lifting	❑Sitting	❑Yardwork
❑Bending	❑Driving	❑Looking over shoulder	❑Squatting	
❑Caring for family	❑Eating	❑Lying down	❑Standing	
❑Carrying	❑Falling or staying asleep	❑Pulling	❑Stress	
❑Changing positions	❑Getting in or out of car	❑Pushing	❑Stretching	
❑Climbing stairs	❑Getting out of bed	❑Reaching	❑Talking on telephone	
❑Computer use	❑Getting up from laying down	❑Reading	❑Turning	
❑Concentrating	❑Getting up from sitting	❑Repetitive motions	❑Twisting	
❑Cooking	❑Grocery shopping	❑Resting	❑Walking	

Past episodes for this complaint?
❑Yes ❑No

Past care for this complaint?
❑Yes ❑No

COMPLAINTS/SYMPTOMS

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❑Concentrating	❑Getting up from sitting	❑Repetitive motions	❑Twisting	
❑Cooking	❑Grocery shopping	❑Resting	❑Walking	

Past episodes for this complaint?
❑Yes ❑No

Past care for this complaint?
❑Yes ❑No

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Date of Accident:_____ **Today's Date**:_____

Patient's Name:_____

The vehicle <u>YOU</u> were in:

<u>Vehicle type:</u>

❑Car ❑Truck
❑SUV
❑Pickup ❑Other_____

<u>Vehicle size</u>:

❑Mini ❑Very large
❑Small ❑With a load
❑Mid-size ❑Without a load
❑Large ❑Other_____

The <u>OTHER</u> vehicle involved in the collision:

<u>Vehicle type:</u>

❑Car ❑Truck
❑SUV
❑Pickup ❑Other_____

<u>Vehicle size</u>:

❑Mini ❑Very large
❑Small ❑With a load
❑Mid-size ❑Without a load
❑Large ❑Other_____

<u>YOUR position in the vehicle:</u>

❑Driver ❑Front Seat Passenger
❑Rear Right Passenger ❑Rear Left Passenger
❑Rear Middle Passenger
❑Rear Passenger in car seat/booster

<u>Were you wearing a seatbelt?</u> ❑Yes ❑No
<u>Did airbag deploy?</u> ❑Yes ❑No

<u>Direction you were looking of at time of impact?</u>

❑Unsure ❑Straight ahead
❑Down ❑To the left
❑Over left shoulder ❑ To the right
❑Over right Shoulder

<u>Did you come in contact with interior of vehicle?</u>

❑Yes ❑No

<u>What part of your body came in contact?</u>

❑Back of head / Neck ❑Front of head ❑Left side of head ❑Right side of head
❑Left shoulder ❑Left arm ❑Left leg ❑Left foot ❑Left knee
❑Right shoulder ❑Right arm ❑Right leg ❑Right foot ❑Right knee
❑Trunk / flank ❑Chest/Ribs

<u>What part of the vehicle did you contact?</u>

❑Airbag ❑Armrest ❑Dashboard ❑Door ❑Flying objects
❑Window ❑Head rest ❑Seat ❑Steering wheel

<u>Did you receive an injury to the head?</u>

❑Yes ❑No

<u>Did you lose consciousness?</u>

❑Yes ❑No

<u>Where was the impact on YOUR vehicle?</u>

❑Front right side ❑Front left side ❑Front center
❑Rear right side ❑Rear left side ❑Rear center
❑Right side ❑Left side

<u>YOUR vehicle's movement at impact?</u>

❑Backing up ❑Moving forward ❑Stopped ❑Turning left ❑Turning right

<u>Approximate speed of YOUR vehicle:</u>

❑Not moving ❑ less than15 MPH ❑15-25 MPH ❑25-40 MPH ❑40-65 MPH ❑65+MPH ❑Unknown

Extent of damage to YOUR vehicle:

❑Heavy visible damage ❑Moderate visible damage ❑Slight visible damage
❑No visible damage ❑Totaled ❑Unknown

OTHER vehicle's movement at impact?

❑Backing up ❑Moving forward ❑Stopped ❑Turning left ❑Turning right

Approximate speed of OTHER vehicle:

❑Not moving ❑ less than15 MPH ❑15-25 MPH ❑25-40 MPH ❑40-65 MPH ❑65+MPH ❑Unknown

Extent of damage to OTHER vehicle:

❑Heavy visible damage ❑Moderate visible damage ❑Slight visible damage
❑No visible damage ❑Totaled ❑Unknown

Was your vehicle towed from the scene? ❑Yes ❑No
Did police arrive on scene? ❑Yes ❑No
Was an accident report taken? ❑Yes ❑No
Emergency Medical Services at scene? ❑Yes ❑No
Did You lose consciousness? ❑Yes ❑No

Where did you go after the accident...?

❑Arranged for a ride home ❑Continued on with activities ❑Denied transport / medical attention
❑Was driven to hospital ❑Drove home ❑Transported to hospital by ambulance

What treatment, if any, have your received since the accident? Choose all that apply:

❑No treatment ❑Referred to Chiropractor
❑Admitted to hospital ❑Referred to Primary Care Physician
❑Examined ❑Treated by self with heat / cold therapy
❑Prescribed medication ❑Treated by self with Over The Counter medications
❑X-rayed

Describe the discomfort you IMMEDIATELY felt at the scene? Choose all that apply

❑Aching ❑Deep ❑Heavy ❑Sharp ❑Throbbing
❑Annoying ❑Diffuse ❑Intolerable ❑Shock like ❑Tightness
❑Burning ❑Dull ❑Pulling ❑Stabbing ❑Tingling

In what areas did you IMMEDIATELY feel pain? Choose all that apply

❑Back of head ❑Front of head ❑Left side of head ❑Right side of head
❑Back of neck ❑Front of neck ❑Left side of neck ❑Right side of neck
❑Right mid back ❑Left mid back ❑Center mid back
❑Right low back ❑Left low back ❑Center low back
❑Abdomen ❑Chest
❑Front of ribs ❑Back of ribs ❑Right side of ribs ❑Left side of ribs
❑Front of RIGHT shoulder ❑Upper arm ❑Elbow ❑Wrist ❑Hand
❑Back of RIGHT shoulder ❑Upper arm ❑Elbow ❑Wrist ❑Hand
❑Front of LEFT shoulder ❑Upper arm ❑Elbow ❑Wrist ❑Hand
❑Back of LEFT shoulder ❑Upper arm ❑Elbow ❑Wrist ❑Hand
❑Front of RIGHT hip ❑Thigh ❑Knee ❑Leg ❑Ankle ❑Foot
❑Back of RIGHT hip ❑Thigh ❑Knee ❑Leg ❑Ankle ❑Foot
❑Front of LEFT hip ❑Thigh ❑Knee ❑Leg ❑Ankle ❑Foot
❑Back of LEFT hip ❑Thigh ❑Knee ❑Leg ❑Ankle ❑Foot

Addition symptoms at time of collision? Choose all that apply:

❑Anxiety	❑Exhaustion	❑Loss of Appetite	❑Sleeping Difficulty	❑Tired
❑Breathing Difficulty	❑Facial Pain	❑Low energy	❑Soreness	❑Upset
❑Chest Pain	❑Genital pain	❑Muscle Spasm	❑Stomach pain	
❑Depression	❑Gluteal Pain	❑Numbness/Tingling	❑Stress	
❑Disbelief	❑Headaches	❑Rib Pain	❑Stunned	
❑Dizziness	❑Irritability	❑Shock	❑Tightness	

Status of symptoms since the collision? Choose all that apply:

❑Elicited more pain	❑Worsened	❑Improved	❑Lessened
❑Elicited more stiffness	❑Worsened quality of life	❑Improved daily function	❑Somewhat resolved
❑Exacerbated	❑No change daily function	❑Elicited less pain	❑Stayed the same
❑Decreased daily function	❑Disappeared	❑Elicited less stiffness	

Why did you continue to work?

❑I would lose my job if I took time off
❑My business would fail if I did not work
❑I could not support my family otherwise
❑I can't take time off work because I care for my kids
❑I don't believe intaking time off even when hurt

Problems with mobility / stability? Choose all that apply:

❑Climbing ❑Kneeling ❑Lifting ❑Walking for long periods

Problems with dexterity?

❑Finger movements ❑Wrist movements

Do you experience fatigue? ❑Yes ❑No
Do you experience depression? ❑Yes ❑No
Do you experience ringing in your ears? ❑Yes ❑No
Do you experience problems with posture? ❑Bending ❑Sitting for long periods ❑Stooping ❑Standing
Do you experience problems concentrating? ❑Can't concentrate ❑Can't think properly ❑Making mistakes

Areas of pain at work? Choose all that apply:

❑Back of head	❑Front of head	❑Left side of head	❑Right side of head		
❑Back of neck	❑Center mid back	❑Center low back	❑Chest	❑Ribs	
❑RIGHT shoulder	❑Upper arm	❑Elbow	❑Arm	❑Wrist	❑Hand
❑LEFT shoulder	❑Upper arm	❑Elbow	❑Arm	❑Wrist	❑Hand
❑RIGHT hip	❑Thigh	❑Knee	❑Leg	❑Ankle	❑Foot
❑LEFT hip	❑Thigh	❑Knee	❑Leg	❑Ankle	❑Foot

Do you experience problems at home? Choose all that apply:

❑Laundry	❑Dish washing	❑Vacuuming
❑Washing windows	❑Cleaning	❑Preparing meals

Patient's Signature:_____DATE:_____