Date: _____
Patient # _____

Automobile Accident History

Last _____ First _____ Middle Initial _____ Birth Date _____ Age _____

Address _____ City _____ ST _____ Zip _____

Phone (H) _____ (W) _____ (C) _____

Email _____ May we send you our online newsletter? ☐yes ☐no

Occupation _____ Employer _____

Spouse's Name _____ Business/Employer _____ Spouse Phone: _____

Who is your primary care physician? _____ Address: _____

Phone: _____ Date of last physical/exam? _____ With Whom? _____

Date of Accident: _____ Time of Accident: _____ am / pm ☐Daylight ☐Dawn ☐Dusk ☐Dark

Road conditions at the time of the accident: ☐Wet ☐Dry ☐Snow ☐Ice ☐Other _____

Was the accident on the job? ☐Yes ☐No Where you in a company vehicle? ☐Yes ☐No

Where were you seated in the vehicle? ☐Driver ☐Passenger ☐Rear-seat ☐Other _____

Were you aware of the approaching collision prior to impact, or did it catch you by surprise? ☐Aware ☐Surprise

Did you lose consciousness upon impact? ☐Yes ☐No Did you experience a flash of light or explosion in your head? ☐Yes ☐No

Did the police come to the accident scene? ☐Yes ☐No Is there a police report? ☐Yes ☐No

Did you go to the hospital? ☐Yes ☐No When? ☐Immediately ☐___hours later ☐___days later Which hospital? _____

How did you get to the hospital? _____ How long did you stay in the hospital? _____

What did the hospital do for your injuries? (collars, splints, x-rays, medication etc.)_____

What areas were x-rayed? _____ What was their diagnosis? _____

What did they recommend for follow-up care? _____

Was any other doctor consulted after your accident? ☐Yes ☐No If yes, please complete information below.

Dr. _____ Specialty?_____ Date first seen:_____

Type of treatment:_____ Treatment frequency:_____ How long did you treat?_____

Dr. _____ Specialty?_____ Date first seen:_____

Type of treatment:_____ Treatment frequency:_____ How long did you treat?_____

Were you wearing a seatbelt? ☐Yes ☐No If yes, did you receive any injury or bruise from the seat belt? ☐Yes ☐No

Did your head hit the head rest during the accident? ☐Yes ☐No If adjustable, was the position of the head rest altered? ☐Yes ☐No

Was the seat adjustment altered by the accident? ☐Yes ☐No Was the seat broken by the accident? ☐Yes ☐No

Did the air-bag deploy? ☐Yes ☐No If yes, did it strike you? ☐Yes ☐No If yes, where? _____

Which way was your head pointing at the point of impact? ☐Straight ☐Right ☐Left Body? ☐Straight ☐Right ☐Left

Where were your hands? ☐One on the wheel ☐Both on the wheel ☐Not Applicable

Were you wearing a hat or glasses at the time of impact? ☐Yes ☐No If so, were they still on after the accident? ☐Yes ☐No

YOUR CAR

List the year, make and model of the car you were in: YEAR: _____ MAKE: _____ MODEL: _____

Was your car stopped at the time of impact? ☐Yes ☐No If yes, was the driver's foot on the brake? ☐Yes ☐No If no, estimate the speed of the vehicle you were in: _____mph

If your vehicle was moving at the time of impact, was it: ☐Slowing down ☐Gaining speed ☐Steady speed

THE OTHER CAR

List the year, make and model of the other car : YEAR: _____ MAKE: _____ MODEL: _____

Was the other car moving at the time of impact? ☐Yes ☐No If yes, what was the approximate speed of the vehicle : _____mph

At the time of impact, was the other car: ☐Slowing down ☐Gaining speed ☐Steady speed

Please describe, to the best of your knowledge, what happened during this accident.

_____

_____

_____

_____

_____

_____

You may draw the accident here

AUTOMOBILE INSURANCE INFORMATION

Driver of the automobile you were in: _____ **Name of their auto insurance:** _____

Policy #: _____ **Claim #:** _____

Auto insurance phone #: _____ **Name of insurance adjuster:** _____

Driver of the other vehicle: _____ **Name of their auto insurance:** _____

Policy #: _____ **Claim#:** _____

Auto insurance phone #: _____ **Name of insurance adjuster:** _____

At the time of the accident, did you become or experience any of the following? ☐Confused ☐Disoriented ☐Light headed ☐Dizzy ☐Nauseated ☐Blurred vision ☐Ringing/Buzzing in ears ☐Loss of balance ☐Other: _____

Do you still have any of those symptoms? ☐Yes ☐No **If yes, which ones?** _____

Check symptoms you have noticed since the accident.

☐ Headaches/Migraines	☐ Neck Pain	☐ Upper Back Pain	☐ Shoulder Pain	☐ Midback Pain
☐ Low Back Pain	☐ Depression	☐ Buzzing In Ears	☐ Arm/Leg Pain	☐ Jaw Pain/Clicking
☐ Dizziness	☐ Fatigue	☐ Loss of Memory	☐ Cold Hands/Feet	☐ Numbness/Tingling
☐ Loss of Smell	☐ Irritability	☐ Digestive Problems	☐ Joint Pain/Stiffness	☐ Menstrual Problems
☐ Pinched Nerve	☐ Loss of Sleep	☐ Loss of Balance	☐ Chest Pain	☐ Light Bothers Eyes
☐ Fever	☐ Nervousness	☐ Vision Problems	☐ Urinary Problems	☐ Sleeping Problems
☐ Paralysis	☐ Tension	☐ Fainting	☐ Pins/Needles Feeling	☐ Stomach Upset
☐ Difficulty Swallowing	☐ Sciatica	☐ Sinus Pain	☐ Sore Muscles	☐ Head Feels To Heavy
☐ Other:				

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Date:

Last Name: _____ First Name:_____ M.I. _____

I Would Prefer To Be Called: _____

Age: _____ Occupation: _____ Employer: _____

Spouse's Name: _____ Number of Children: _____

How did you hear about us? : _____

Have You Been Treated By A Chiropractor In The Past? Yes No (circle one)

If So, Where: _____

Tobacco Use:
Alcohol Use:
Work Activities (desk work, labor, etc):
Activity Level: None Light Moderate Vigorous
Hospitalizations (date/reason):
Prior Surgeries (date/location):
Prior Accidents / Injuries (date/injury):
Ongoing Illness, Pains:
Current Medications:
Family History:
Hobbies, Activities, Sports:
Previous Physical, X-rays, Imaging (date/findings):
Dietary Habits, Water Intake:
Nutritional Supplements (vitamins, protein, supplements):
Additional Notes for the Doctor:

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Please check the box next to each condition you have experienced or are experiencing.

GENERAL

- ☐ Lethargy / Weakness
- ☐ Recurring fever
- ☐ Recent weight loss or gain
- ☐ Dizziness
- ☐ Fever
- ☐ Chills
- ☐ Others:

CARDIOVASCULAR

- ☐ Chest pain or tightness
- ☐ Heart attack
- ☐ Shortness of breath
- ☐ Palpitations
- ☐ Swelling of feet or hands
- ☐ High blood pressure
- ☐ High cholesterol or triglycerides
- ☐ Heart murmur
- ☐ Blood clots
- ☐ Pacemaker
- ☐ Mitral valve prolapse
- ☐ Congenital heart defects
- ☐ Rheumatic fever
- ☐ Leg pain upon walking
- ☐ Varicose veins
- ☐ Dizziness
- ☐ Excessive bruising
- ☐ Coronary artery disease
- ☐ Others:

ALLERGIES

- ☐ Seasonal
- ☐ Medication
- ☐ Food
- ☐ Others:

EENT

- ☐ Headaches or migraines
- ☐ Eye or vision problems
- ☐ Eyeglasses or contact lenses
- ☐ Nose bleeds
- ☐ Eye surgery
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Swollen glands
- ☐ Nose congestion / sinus trouble
- ☐ Ear or hearing problems
- ☐ Dental problems
- ☐ Gum problems
- ☐ TMJ problems
- ☐ Postnasal drip
- Others:

RESPIRATORY

- ☐ Persistent cough
- ☐ Spitting up blood
- ☐ Asthma or wheezing
- ☐ Shortness of breath
- ☐ Exercise intolerance
- ☐ Sleep apnea
- ☐ Emphysema
- ☐ Snoring issues
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Breathing
- ☐ Hay fever
- ☐ Others:

SKIN / HAIR

- ☐ Skin trouble or rashes
- ☐ Flushing
- ☐ Excessive acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin cancer
- ☐ Skin pigmentation issues
- ☐ Change in hair or nails
- ☐ Blood in stool
- ☐ Easy bruising
- ☐ Gum bleeding
- ☐ Others:

GASTROINTESTINAL

- ☐ Loss of appetite
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Stomach ulcer
- ☐ Bloating/Cramping
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Cirrhosis
- ☐ Difficulty swallowing
- ☐ Jaundice
- ☐ Liver disease
- ☐ Gallbladder problems
- ☐ Pancreatitis
- ☐ Change in bowel habits
- ☐ Black or bloody stool
- ☐ Colon cancer or colon polyps
- ☐ Food sensitivities
- ☐ Irritable bowel syndrome
- ☐ Crohn's disease
- ☐ Gastric reflux
- ☐ Colitis
- ☐ Others:

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NEUROLOGICAL

- [ ] Frequent headaches
- [ ] Migraines
- [ ] Dizziness
- [ ] Fainting
- [ ] Memory loss
- [ ] Poor balance
- [ ] Numbness or tingling
- [ ] Pins and needles
- [ ] Epilepsy or seizures
- [ ] Stroke
- [ ] Tremors
- [ ] Head injury
- [ ] Anxiety and/or panic
- [ ] Depression
- [ ] Sleeping issues
- [ ] Weak muscles
- [ ] Loss of smell or taste
- [ ] Temporary loss of vision
- [ ] Difficulty concentrating
- [ ] Others:

URINARY

- [ ] Painful or frequent urination
- [ ] Incontinence
- [ ] Hesitancy
- [ ] Urgency
- [ ] Blood in urine
- [ ] Kidney stones
- [ ] Urinary infections
- [ ] Genital / bladder / urinary complaints
- [ ] Others:

MUSCULOSKELETAL

- [ ] Arthritis
- [ ] Joint pain or swelling
- [ ] Neck pain
- [ ] Back pain
- [ ] Trauma
- [ ] Osteoporosis
- [ ] Scoliosis
- [ ] Cramping
- [ ] Fractures
- [ ] Implants, plates, pins or screws
- [ ] Hip disorders
- [ ] Knee injuries
- [ ] Foot / ankle pain
- [ ] Shoulder problems
- [ ] Elbow / wrist pain
- [ ] Poor posture
- [ ] Gout
- [ ] Others:

PSYCHIATRIC

- [ ] Alzheimer's Disease
- [ ] Insomnia
- [ ] Difficulty concentrating
- [ ] Memory loss/confusion
- [ ] Depression
- [ ] Anxiety
- [ ] Agitation/Irritability
- [ ] Suicidal thoughts
- [ ] Chemical dependency
- [ ] Others:

BLOOD / LYMPH

- [ ] Anemia
- [ ] Bleeding
- [ ] Bruising
- [ ] Blood clots
- [ ] Past transfusions
- [ ] Leukemia
- [ ] Lymphoma
- [ ] HIV/AIDS
- [ ] Sickle cell
- [ ] Others:

ENDOCRINE

- [ ] Diabetes
- [ ] Thyroid problems
- [ ] Sweating
- [ ] Heat intolerant
- [ ] Cold intolerant
- [ ] Weight loss
- [ ] Weight gain
- [ ] Frequent urination
- [ ] Excessive thirst
- [ ] Change in appetite
- [ ] Hair changes
- [ ] Hyperthyroidism
- [ ] Hormonal / glandular concerns
- [ ] Hyperparathyroidism
- [ ] Testosterone deficiency
- [ ] Cushing's syndrome
- [ ] Steroid treatments
- [ ] Others:

ANY ADDITIONAL COMPLAINTS YOU WOULD LIKE THE DOCTOR TO KNOW ABOUT?

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Primary Complaint:

Additional Complaints:

DATE OF INJURY / SYMPTOM ONSET:

TREATMENT RECEIVED : MEDICATION – SURGERY – CHIROPRACTIC – PHYSICAL THERAP Y – OTHER – NONE

HOW DID YOUR INJURIES HAPPEN:

SYMPTOMS EXPERIENCED: CONSTANTLY - FREQUENTLY - OCCASIONALLY - INTERMITTENTLY

SYMPTOMS INTEREFERE WITH: WORK – SLEEP – DAILY ROUTINE – RECREATION

ACTIVITIES PAINFUL TO PERFORM:

WHAT WORSENS YOUR SYMPTOMS:

WHAT IMPROVES YOUR SYMPTOMS / PROVIDES RELIEF:

ARE YOUR SYMPTOMS GETTING WORSE: YES NO HOW? :

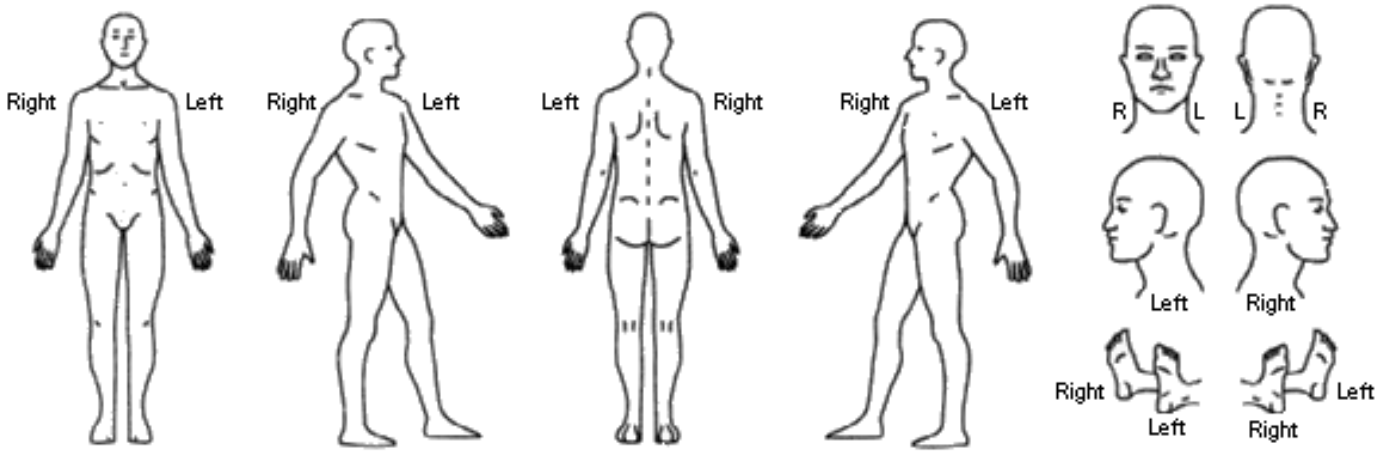
OVERALL HEALTH: (CIRCLE BEST ANSWER): EXCELLENT - VERY GOOD - GOOD - FAIR - POOR

CIRCLE YOUR AVERAGE PAIN INTENSITY

- **CURRENT PAIN LVL:** **1 2 3 4 5 6 7 8 9 10**
- **AVERAGE PAIN LVL:** **1 2 3 4 5 6 7 8 9 10**

TYPES OF PAIN: Mark all that apply

☐ ACHING ☐ DULL ☐ STABBING ☐ NUMBNESS ☐ TINGLING
☐ BURNING ☐ SHARP ☐ THROBBING ☐ STIFFNESS ☐ OTHER



MARK THE PAINFUL REGIONS ON THE DIAGRAMS ABOVE WITH (X).

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Dr. Jonathan Engstrom DC, CCSP, CKTP

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, massage therapy to myself (or on the patient named below, for whom I am legally responsible) by the chiropractic physician and/or any employee at Center For Wellness authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician of Chiropractic Medicine ___Dr. Jonathan Engstrom___ and/or other employees who may treat me now or in the future at Center For Wellness. I understand the nature and purpose of chiropractic adjustments and other procedures, and that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic care carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of treatment which the physician feels is in my best interest at the time based upon the objective information present.

I have read, or have been read to, the above consent. I have also had an opportunity to ask questions about the contents of the consent form, and by signing below, I agree to the treatment recommended by my physician. I acknowledge that the Notice of Privacy Practices for Center For Wellness has been made available to me at the time of my signing this consent form. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at Center For Wellness.

Furthermore, by signing below I acknowledge that I will be subject to a charge of **$25.00** if I fail to cancel or reschedule an appointment within 24 hours of my scheduled appointment with Center For Wellness.

_____ Print Patient Name (Adult)

_____ Patient Signature

_____ Print Patient Name (Minor)

_____ Print Representative / Guardian Name

_____ Representative / Guardian Signature