ABOUT YOU

First Name _____ **Middle Name** _____

Last Name _____

Street Address _____

Line 2 - Apartment Number _____

City _____ **State** _____ **Zip** _____

Mobile Phone ____-____-_____ **Work Phone** ____-____-_____ **Home Phone** ____-____-_____

Email _____

Date of Birth ____ / ____ / _____ **Gender** ☐ Male ☐ Female

Height _____'_____" **Weight** _____ lbs

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Number of Children _____ **Spouse's Name** _____

EMERGENCY CONTACT INFORMATION.

Name _____

Phone ____-____-_____ **Relation To You** _____

INSURANCE INFORMATION

Do you have Insurance? ☐ Yes ☐ No

Insurance Name _____ **Phone** ____-____-_____

Address Line 1 _____

Address Line 2 _____

City _____ **State** _____ **Zip** _____

ID/Policy Number _____ **Group Number** _____

Insured's Name _____ **Insured's Date of Birth** ____ / ____ / _____

REFERRAL INFORMATION

Referring Physician _____ **Contact information.** _____

Referring Patient _____

Are you working with an attorney? ☐ Yes ☐ No

How did you hear about us?

☐ Word of mouth ☐ Advertisement ☐ Social media ☐ Direct marketing ☐ Internet

REASON FOR VISIT

What is the date of your scheduled appointment? ____ / ____ / _____

How long have you had this complaint?

- ☐ Less than 5 days (Acute)
- ☐ Between 5-30 days (Sub Acute)
- ☐ More than 30 days (Chronic)

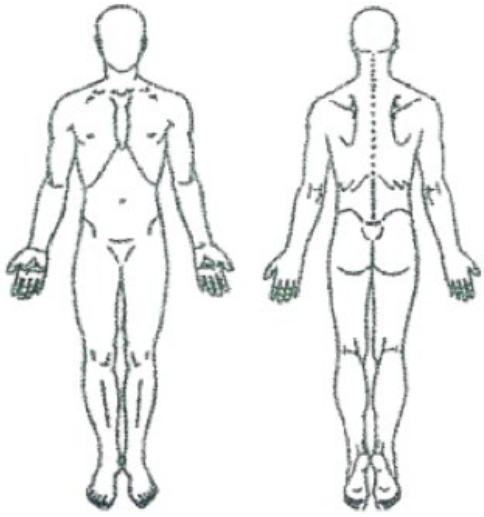
What caused this condition _____

What is the date this condition began? (Skip if due to accident) ____ / ____ / _____

What term(s) describes your discomfort best? _____

On the body diagrams to the right, please indicate your areas of symptoms by drawing in the appropriate symbols.

P - pain
N - numbness
W - weakness
S - shooting
A - Aching



On a scale of 1 to 10, with 10 being the most severe, how do you rate your discomfort?

None ***Unbearable***

0 1 2 3 4 5 6 7 8 9 10

How often do you feel this discomfort? ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

How has this complaint changed since the onset? ☐ Worsened ☐ Remained the same ☐ Improved

What activity is most significantly affected by this discomfort? (Explain) _____

_____

What treatment, if any, have you received since the accident? _____

_____

What aggravates this condition? _____

What improves this condition or gives you relief? _____

Have other health care provider(s) performed tests related to this condition? _____

_____

Have you ever had any previous episodes of this condition? _____

_____

CURRENT HEALTH

Other than the information already provided, do you have additional health concerns involving any of the following?

Muscles, Bones or Joints	☐ No	☐ Yes	**Explain:** _____
Nerves, Headaches, Dizziness, or Emotional	☐ No	☐ Yes	**Explain:** _____
Head, Eyes, Ears, Nose or Throat	☐ No	☐ Yes	**Explain:** _____
Heart, Blood Pressure, or Circulation	☐ No	☐ Yes	**Explain:** _____
Shortness of Breath, Coughing, Asthma or Lung Condition	☐ No	☐ Yes	**Explain:** _____
Stomach, Bowels or Digestive Conditions	☐ No	☐ Yes	**Explain:** _____
Genital, Bladder, or Urinary Conditions	☐ No	☐ Yes	**Explain:** _____
Diabetes, Thyroid or Glandular Conditions	☐ No	☐ Yes	**Explain:** _____
Skin or Bleeding Conditions	☐ No	☐ Yes	**Explain:** _____
Allergies or Sensitivities	☐ No	☐ Yes	**Explain:** _____

PERSONAL AND FAMILY HISTORY

Have you had any surgical procedures? ☐ No ☐ Yes **Explain:** _____

Are there any past illnesses or conditions we should be aware of? ☐ No ☐ Yes **Explain:** _____

Do you have a past history of accidents or trauma? ☐ No ☐ Yes **Explain:** _____

Are there any past illnesses or conditions we should be aware of? ☐ No ☐ Yes **Explain:** _____

Are you presently taking any medication? ☐ No ☐ Yes **Explain:** _____

Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of? ☐ No ☐ Yes **Explain:** _____

WORK SOCIAL HABITS

Current work habits - Choose all that apply.

- ☐ Permanently fully disabled
- ☐ Permanently partially disabled
- ☐ Cannot work due to current condition
- ☐ Full-time (20-40+ hours/week)
- ☐ Part-time (1-19 hours/week)
- ☐ Retired ☐ Student ☐ Homemaker ☐ Unemployed

Personal social habits - Choose all that apply.

- ☐ Smoke or use tobacco products
- ☐ Drink alcohol
- ☐ Drink caffeine
- ☐ Use recreational drugs
- ☐ Other, to be discussed with doctor

Present exercise habits - Choose all that apply.

- ☐ No current exercises
- ☐ Exercises daily
- ☐ Exercises 3+ times per week
- ☐ Cannot return to exercise due to current condition

Diet and nutrition habits - Choose all that apply.

- ☐ Vegan or vegetarian
- ☐ Daily supplements
- ☐ Other

INFORMED CONSENT TO TREATMENT

I certify that I"m the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I"m responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Signature: _____ **Date:** ____ / ____ / _____

PERSONAL INJURY - AUTO/CYCLE ACCIDENT HISTORY

Skip to the next section if your injury is not auto-related

What type of accident caused your injury?

☐ Two or more automobiles
☐ Injured by a vehicle as a pedestrian
☐ Motorcycle/Bicycle and no Vehicle
☐ An automobile and a Motorcycle/Bicycle ☐ Other

When did the accident occur? ____ / ____ / _____

Where in the vehicle were you at the time of the accident? _____

What were you doing at the time of the accident? _____

In what direction were you looking at the time of impact? _____

What is the size/type of your vehicle? _____

Were you wearing a seatbelt? ☐ Yes ☐ No

What type of protection did you have? _____

Did the airbag deploy? ☐ Yes ☐ No

Did you come in contact with anything at the time of the collision? ☐ Yes ☐ No _____

What was the position of the headrest (in relation to your head)? _____

Did you receive an injury to the head? ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No

Did police arrive at the scene? ☐ Yes ☐ No

Was an accident report taken? ☐ Yes ☐ No

Which part of your vehicle was impacted? Choose all that apply.

☐ Front right ☐ Front left ☐ Front head on
☐ Rear end - center ☐ Rear right ☐ Rear left
☐ Left side (driver's side) ☐ Right side (passenger's side)
☐ Unknown

What type of protection did you have? _____

In what direction was your vehicle or cycle moving?	_____
What was the estimated speed of your vehicle or cycle?	_____
What was the extent of the damage to your vehicle?	_____
What was the extent of the damage to the other vehicle or cycle?	_____
In what direction was the other vehicle or cycle moving?	_____
What was the estimated speed of the other vehicle or cycle?	_____
Was your vehicle or cycle towed from the scene?	☐ Yes ☐ No
Did Emergency Medical Services arrive at the scene?	☐ Yes ☐ No
How did you leave the scene of the accident?	_____
Where was discomfort felt immediately following the accident?	_____
Describe your discomfort after the accident.	_____
What treatment, if any, have you received since the accident?	_____
Are there any additional symptoms which have appeared since the accident occurred?	☐ Yes ☐ No _____
How have your symptoms changed since the accident?	☐ Worsened ☐ Remained the same ☐ Improved

PERSONAL INJURY - NON-AUTO ACCIDENT HISTORY

What type of accident caused your injury?

☐ Work injury (but not auto related) ☐ Slip and fall (away from home)
☐ Home Injury ☐ Sports injury ☐ Other

What is the date of your scheduled appointment? ____ / ____ / _____

When did the accident occur? ____ / ____ / _____

What were you doing at the time of the accident? _____

In what direction were you looking at the time of impact? _____

Did you receive an injury to the head? ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No

Did police arrive at the scene? ☐ Yes ☐ No

Was an accident report taken? ☐ Yes ☐ No

Did Emergency Medical Services arrive at the scene? ☐ Yes ☐ No

How did you leave the scene of the accident? _____

Where was discomfort felt immediately following the accident? _____

Describe your discomfort after the accident. _____

What treatment, if any, have you received since the accident? _____

Are there any additional symptoms which have appeared since the accident occurred? ☐ Yes ☐ No
_____

How have your symptoms changed since the accident? ☐ Worsened ☐ Remained the same ☐ Improved