PERSONAL PATIENT INFORMATION

The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of the form. If you need any help, please ask the receptionist.

How did you hear about this office? ____________________

Is this visit to this clinic in reference to a work related or automobile accident? (Please Circle) Yes No (If yes, please fill out back of form)

PATIENT DATA (Please Print)

Please Circle Daytime Number

Cell ____________

Home ____________

Work ____________

Name ____________________
FIRST MIDDLE LAST

Preferred name you would like to be called ____________________

Address ____________________ City ____________

State ________ Zip Code ________ Age ________ Date of Birth ____________ Marital Status M S D W

Employer/Occupation ____________________

Name of Nearest Relative ____________________ Phone Number ____________

Please describe the location of the major complaint and how it feels: ____________________

____

Briefly explain how the problem occurred: ____________________

____

When did you first notice this? (Please specify the approximate date) ____________________

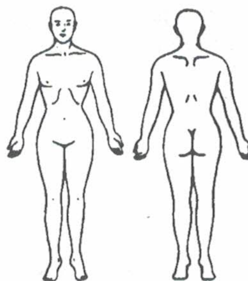
List any other complaints or health problems: ____________________

____

Have you received chiropractic care before? (Please Circle) Yes No (If yes, when ____________________)

SHADE IN THE AREA OF PAIN AND CIRCLE THE SEVERITY NUMBER

1 = MILD PAIN 10 = SEVERE PAIN



1 2 3 4 5 6 7 8 9 10

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I am accepted as a patient by the chiropractor, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risks regarding the chiropractic treatment will be explained to me upon my request.

Patient's Signature ____________________ **Date** ____________

WORK RELATED OR AUTO RELATED ACCIDENTAL INJURY REPORT

If your visit to this clinic is due to an accident of any type, please review all events associated with the accident.

Date of accident ______________________ Hour ________ am/pm Location ______________________

How did accident occur? Auto Collision On-the-job injury Other ______________________

Please describe the circumstances. ______________________

____

____

(Please Circle)

Did you report the injury to the supervision of personnel office? Yes No

Did he (they) recommend care at our office? Yes No

If auto accident: were you: Driver Passenger Pedestrian

If auto collision, were you struck from: Behind Right Side Left Side Front Auto was parked

Did your car strike the other(s) involved? Yes No

Or did the other car strike yours? Yes No Undetermined

As a result of the accident, were traffic citations issued to you? Yes No

To the driver of the other car? Yes No To the driver of your car? Yes No

List the extent of the injuries as you know them: ______________________

____

____

Did you require hospitalization or emergency room treatment after the accident? Yes No

Where ______________________

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

_____ shortness of breath
_____ excessive perspiration
_____ mid back (pain, stiffness)
_____ low back (pain, stiffness)
_____ swelling (where) ____________
_____ feet cold, hands cold
_____ restriction of neck motion
_____ upper back pain and stiffness
_____ buzzing and/or ringing of ears
_____ eyes sensitive to light, loss of focus
_____ head and shoulders feel tired, heavy
_____ pins and needles in (arms, legs)
_____ numbness in (fingers, arms, legs)
_____ difficulty in riding in a car
_____ headache
_____ neck pain
_____ neck stiffness
_____ tension
_____ irritability

_____ anxiety
_____ fainting
_____ chest pain
_____ dizziness
_____ eyestrain
_____ nausea, vomiting
_____ tremors
_____ sinus troubles
_____ mental dullness
_____ extreme fatigue
_____ pain behind eyes
_____ double vision
_____ digestive disorders
_____ equilibrium problems
difficulty in excessive
standing _____ walking _____
riding _____ bending _____

_____ neck (pain stiffness) upon rising
_____ low back (pain stiffness) upon rising
_____ pain radiating into
arm _____ leg _____
right _____ left _____ both _____
difficulty in lifting
light _____ moderate _____
heavy _____ after a few times

Symptoms other than above ______________________

Have you lost any workdays? Dates from ______________ to ______________

INSURANCE COMPANIES INVOLVED:

Your insurance company name ______________________

Insurance company of person responsible for injuries ______________________

Have you been contacted by an insurance adjuster or company representative regarding this claim? (Please Circle) Yes No

Do you have an attorney that has advised you in this case? (Please Circle) Yes No

Attorney's Name ______________________ Phone ______________

Attorney's Address ______________________