

INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. **PLEASE PRINT.**

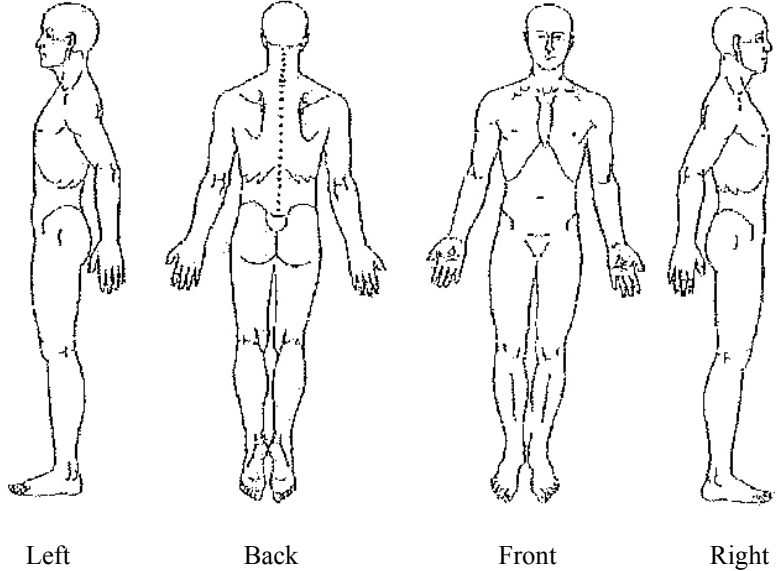
Name _____ Today's Date _____
Address _____ City _____ State _____ Zip _____
Age _____ Birthday _____ Marital Status: S M W D Number of Children _____
Home Phone _____ Work Phone _____ Cell _____
Insurance Company _____ Insurance/Claim ID# _____
Claims Adjuster Name _____ Insurance Phone # _____
Social Security # _____
In Case of Emergency Who Should We Contact _____ Phone # _____
Primary Medical Doctor Name _____ Phone # _____
Address _____ City _____ State _____ Zip _____
Can we contact them to coordinate care if needed? Yes _____ No _____

In your own words, please describe the accident: _____

Using the adjacent body charts, please circle all affected areas.

Please rate your pain with the following scale:
No Pain 1 2 3 4 5 6 7 8 9 10 Severe Pain

Are you taking any medications or supplements?



Signature _____ Date _____

Patient Name _____

Date _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

- | | | | | |
|-----------------------------|--------------------------------|-------------------------|-------------------------------|---------------------------|
| Y N Heart Attack/Stroke | Y N Heart Surgery/Pacemaker | Y N Heart Murmur | Y N Congenital Heart Defect | Y N Mitral valve Prolapse |
| Y N Artificial Valves | Y N Alcohol/Drug Abuse | Y N Venereal Disease | Y N Hepatitis | Y N Anemia/Diabetes |
| Y N Shingles | Y N Cancer | Y N Frequent Neck Pain | Y N Glaucoma | Y N Kidney Problems |
| Y N High/Low Blood Pressure | Y N Psychiatric Problems | Y N Rheumatic Fever | Y N Severe/Frequent Headaches | Y N Tuberculosis |
| Y N Ulcers/Colitis | Y N Fainting/Seizures/Epilepsy | Y N Sinus Problems | Y N Emphysema/Asthma | Y N Arthritis |
| Y N Difficulty Breathing | Y N Chemotherapy | Y N Lower Back Problems | Y N Artificial Bones/Joints/ | Y N Recent Fever |

Please list any surgeries with dates and/ or any other serious medical condition(s) not listed above: _____

Please list any past serious accidents with dates: _____

Please list anything that you may be allergic to: _____

Family Health History:

Does your Grandmother, Grandfather, Mother or Father have any of the following:

- Diabetes Heart Disease Stroke Cancer High Blood Pressure

For Women:

Are you pregnant? yes No If yes, how many weeks? _____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____

Date _____

After Injury

Patient Name _____

Date _____

Did the accident render you unconscious? Yes No

If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

Have you gone to a hospital or seen any other doctor? Yes No

When did you go? _____

How did you get there? Ambulance Private transportation

Name of hospital and/or attending doctor: _____

Was he/she a: M.D. D.C. Other _____

Describe any treatment you received: _____

What diagnosis was given: _____

Were X-rays taken? Yes No

If yes, what areas: _____

Was Medication prescribed? Yes No

If yes, please list: _____

Were any supplies given to you? Crutches Cervical Collar Other _____

Have you been able to work since the injury? Yes No

If yes, are your work activities restricted as a result of this injury? Yes No

If yes, please explain how: _____

Indicate the symptoms that are a result of this accident:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Arm/Shoulder pain |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numb hands/fingers |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Leg Pain |
| <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Migraines | <input type="checkbox"/> Tension | <input type="checkbox"/> Numb legs/toes |
| <input type="checkbox"/> Upper Back Stiffness | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Tailbone Pain |
| <input type="checkbox"/> Lower Back Stiffness | <input type="checkbox"/> Buzzing in Ear | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Jaw problems |
| | <input type="checkbox"/> Ears Ringing | <input type="checkbox"/> Stomach upset | <input type="checkbox"/> Other, please list below |
| | | <input type="checkbox"/> Nausea | |

Do you have an attorney who is representing your case? Yes No

Attorney Name _____ Phone # _____

Address _____

Signature _____

Date _____

Auto Accident Information

Patient Name _____

Date _____

Date of accident ____/____/____

Time of accident _____ a.m. p.m.

Were you the: Driver Front Passenger Rear Passenger Pedestrian

Make and model of vehicle you were occupying? _____

If a traffic violation was issued, to whom was it issued? _____

Number of people in the accident vehicle? _____

Did the police come to the accident site? Yes No

Was a police report filed? Yes No

Were there any witnesses? Yes No

Were you wearing a seat belt? Yes No

Was this vehicle equipped with airbags? Yes No

If yes, did it/they inflate? Yes No

In relation to the base of your skull, where was the headrest? Above Below Behind

What did your vehicle impact? Another vehicle Other

If other, explain: _____

Did any part of your body strike anything in the vehicle? Yes No

If yes, please describe: _____

Name of the location/street on which you were traveling? _____

In which direction were you headed? North South East West

What was the approximate speed of your vehicle? _____

Did the impact to your vehicle come from the: Front Rear Right Side Left Side Other

If other, please explain: _____

During Impact, were you facing: Right Left Forward

Were you aware or surprised by the impact?

If accident vehicle made impact with another vehicle.....

Direction other vehicle was headed? North South East West

Approximate speed of the other vehicle? _____ Make, Model, Year of other vehicle: _____

With the space below, could you please draw a diagram of the accident:

Signature _____

Date _____