

**PERSONAL HISTORY**

PT# \_\_\_\_\_ Date \_\_\_\_\_

Please complete this form to the best of your ability. If you need help our receptionist will be glad to assist you!

Full Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (Home) \_\_\_\_\_ Phone (Work) \_\_\_\_\_ Cell \_\_\_\_\_

E-mail \_\_\_\_\_ Sex: M F Single / Separated / Married / Widowed / Divorced

Birth \_\_\_\_\_ Social Security# \_\_\_\_\_ Do you like appointment reminder calls? No/ Cell/ Home

How did you hear about our office? TV Phonebook Newspaper Billboard Website Family/Friend \_\_\_\_\_

Employed / Student / Other Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Date Of Birth \_\_\_\_\_ Social Security# \_\_\_\_\_

**Accident Injury and Insurance Information**

Could your present problems be due to an accident-injury? \_\_\_\_\_ Date \_\_\_\_\_

Type of accident-injury (circle): Auto, On-the-Job, Slip/Fall, Personal, Other **We do not accept assignment on work related injuries.**

Name of Attorney handling your case \_\_\_\_\_ Phone \_\_\_\_\_

Type of Insurance you plan to use to help pay your account (circle): Auto Health Medicare Self-Pay Other

Insurance company \_\_\_\_\_ Phone \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's DOB \_\_\_\_\_

**Your Injury, Illness, or Condition**

What is your injury, illness or condition \_\_\_\_\_

Previous interventions, treatments, medications, surgery, or care you've sought for your injuries \_\_\_\_\_

Do you suffer from any condition other than that which you are now consulting us? \_\_\_\_\_

Have you had previous Chiropractic care? YES NO Condition treated \_\_\_\_\_ Month/Year of last visit \_\_\_\_\_

**Health History / Trauma**

**CIRCLE** conditions you have **NOW** and **UNDERLINE** conditions you have had **PREVIOUSLY**:

- |                               |                       |                     |                     |
|-------------------------------|-----------------------|---------------------|---------------------|
| Low Back Pain                 | Fractured Bones       | Spinal Taps         | Fainting            |
| Arm Pain                      | Dislocation           | Scoliosis           | Birth Defects       |
| Headaches                     | Joint Replacement     | Diabetes            | Osteoporosis        |
| Neck Pain                     | Metal Screws/implants | High Blood Pressure | Cancer              |
| Pain Between Shoulders        | Cervical Whiplash     | Stroke              | Tumor               |
| Leg Pain                      | Electronic Implant    | Aneurysm            | Cyst                |
| Cold/Tingling Fingers or Toes | Pacemaker             | Convulsions         | Ear Infections      |
| Numbness                      | Ruptured Spinal Disc  | Seizures            | Birth Complications |
| Allergies                     | Slipped spinal disc   | Memory Lapse        | Asthma              |
| Loss of Sleep                 | Pinched Nerve         | Dizziness           | Bed Wetting         |
| Stomach/Digestive Problems    | Spinal Surgery        | Concussion          | Heart Disease       |
| Walking problems              | Spinal Infections     | Knocked Unconscious | Fever               |
- Are you Pregnant? Y \_\_\_ N \_\_\_ Other serious illness \_\_\_\_\_

Previous injuries or trauma not listed above \_\_\_\_\_

**Prior Surgeries**

Date \_\_\_\_\_ Type \_\_\_\_\_

Date \_\_\_\_\_ Type \_\_\_\_\_

Date \_\_\_\_\_ Type \_\_\_\_\_

**Current Medications**

Name \_\_\_\_\_ Reason for taking \_\_\_\_\_

Name \_\_\_\_\_ Reason for taking \_\_\_\_\_

Name \_\_\_\_\_ Reason for taking \_\_\_\_\_

**Social and Occupational History** \_\_\_\_\_

Job description \_\_\_\_\_

Recreational Activities \_\_\_\_\_

Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet) \_\_\_\_\_

**Family Health History**

Associated health problems of relatives \_\_\_\_\_

**Treatment Authorization**

**Today you'll receive a free initial consultation with the doctor. If further tests are needed such as exams or x-rays, the necessity and cost will be explained before they are performed. You'll be happy to know that these tests are covered by most insurances.** I hereby authorize this office and its staff and doctors to examine and treat my condition as the doctors deem appropriate. I grant authority for these procedures to be performed. I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment of services by this office. Should collection of past due amount become necessary, I will become responsible for all charges, fees and attorney fees. I (we) hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient's signature (x) \_\_\_\_\_

Date

Entered by \_\_\_\_\_

## Auto Accident Mechanism of Injury Form

Please fill in the blanks or circle the appropriate response(s)

Date of Accident \_\_\_\_\_ Hour of incident \_\_\_\_\_ AM / PM

Please describe how the collision happened \_\_\_\_\_

What was your position in the car? **Driver / Front Passenger / Left Rear / Right Rear**

If "Driver" were your hands on the steering wheel? **Both / Left / Right** Did the airbags deploy? **Yes / No**

Did you strike another vehicle? **Yes / No** Did another vehicle strike your vehicle? **Yes / No**

Angle of Impact: **Front / Back / Left / Right / Other:** \_\_\_\_\_

If Second Collision – Angle of 2<sup>nd</sup> impact: **Front / Back / Left / Right / Other:** \_\_\_\_\_

In relation to the back of your head, was your headrest set: **Low / Middle / High**

Were you surprised by the impact? **Yes / No** If "NO", how did you brace? **With Hands / With Feet**

Where was your head facing at the time of impact? **Straight Ahead / Left / Right / Behind**

Were you leaning forward at the time of impact? **Yes / No**

What type and year of vehicle were you in? \_\_\_\_\_

What was the approximate speed of your vehicle when the accident occurred? \_\_\_\_\_ mph. Speed of other vehicle \_\_\_\_\_ mph

What type and year of vehicle struck yours? \_\_\_\_\_

Were you wearing a seatbelt? **Yes / No** What type: **Lap Belt / Shoulder Belt / Both**

Did you feel pain immediately after the accident? **Yes / No** Were you rendered unconscious? **Yes / No**

Did you strike anything in the vehicle at the time of impact? **Yes / No** If "YES", specify what part of your body struck what: (i.e. head, chest, chin, shoulder, knee, etc.)

<input type="checkbox"/> Steering Wheel	<input type="checkbox"/> Windshield
<input type="checkbox"/> Dashboard	<input type="checkbox"/> Roof
<input type="checkbox"/> Left Side Door	<input type="checkbox"/> Right Side Door
<input type="checkbox"/> Left Window	<input type="checkbox"/> Right Window
<input type="checkbox"/> Other	

Did your seat break or bend? **Yes / No**

Immediately following the accident, how did you feel? (Circle all that apply) **Dizzy / Dazed / Weak / Upset / Disoriented / Nervous / Nauseous / Other:** \_\_\_\_\_

### Police and Ambulance

Was the accident reported to the police? **Yes / No**

Were traffic citations issued? **Yes / No** If "YES", to whom? \_\_\_\_\_

Did you go to the hospital? **Yes / No** If "YES", when? \_\_\_\_\_

If "YES", how did you get there? **Ambulance / Police Car / Private Transportation**

Were you admitted? **Yes / No** If "YES", how long? \_\_\_\_\_

Name of Hospital? \_\_\_\_\_ Attended by Dr. \_\_\_\_\_

What treatment given? (Circle all that apply) **None / X-rays / Pain Medication / Stitches / Muscle Relaxants / Bandaged /**

**Cervical Collar / Physical Therapy / Instructed Regarding Concussion / Instructed Regarding Sprains & Strains /**

**Instructed to Call an Orthopedist / Instructed to Call a Private Physician / Referred to This Office /**

**Other:** \_\_\_\_\_

What other doctor have you seen as a result of this injury? \_\_\_\_\_

Do you have difficulty in excessive: **Standing / Walking / Riding / Bending / Twisting**

Do you have difficulty in excessive lifting: **Light / Moderate / Heavy / Repetitive**

Symptoms other than above: \_\_\_\_\_