NEW PATIENT INFORMATION – PERSONAL INJURY

PERSONAL INFORMATION:

Name: _____
Address: _____
_____
City: _____
State: _____ Zip Code: _____
Daytime Phone #: _____
Other Phone #(s): _____
Date Of Birth: _____ / _____ / _____
Age: _____ Gender: *male / female*
Social Security #: _____ - _____ - _____

Marital Status: *minor / single / engaged / married / legally separated / divorced / widowed*
If Minor, Parent / Guardian: _____
Spouse / Significant Other: _____
If Children, Names & Ages: _____
_____
Any Special Circumstances: _____
_____
Emergency Contact Person: _____
Relationship: _____
Phone #(s): _____

OCCUPATIONAL INFORMATION:

Employment Status: *full-time / part-time / retired stay-at-home / unemployed / student / not applicable*
Place Of Employment: _____
Occupation / Title: _____

At Work, Do You…… (check all that apply)
_____ frequently sit
_____ do repetitious tasks
_____ light / heavy lifting
_____ use computers
_____ frequently stand
_____ bend / stoop
_____ light / heavy labor
_____ other: _____

FINANCIAL INFORMATION:

Have You Settled The Claim? *yes / no*
Did You Hire An Attorney? *yes / no*

Insurance Company: _____
Phone Number: _____
Claim Number: _____

PRESENT HISTORY:

Rate Your Health: *excellent / good / fair / poor*
Rate Your Diet: *excellent / good / fair / poor*
Amount Of Exercise: *regular / irregular / none*
Rate Your Stress Level On The 1-10 Scale (10 = High)
At Home: _____ At Work: _____
Do You Use Any Of The Following? Amount / Day?
_____ Tobacco: _____
_____ Alcohol: _____
_____ Caffeine: _____
Are You Under Medical Care Now? yes / no
If So, For What? _____
Doctor's Name: _____
Last Physical Exam Date: _____
Prescription Drugs? _____
_____
Over – The – Counter Drugs? _____
Supplements? _____

Amount Of Sleep Per Night: _____
I Sleep On My: *back / right side / left side / stomach*
Please Check All That Apply……
_____ I sleep on my stomach.
_____ I sleep with my arms over my head.
_____ I sleep in the fetal position. (curled up)
_____ I sleep twisted. (½ side & ½ back / stomach)
_____ I use more than 1 pillow under my head.
_____ I use a waterbed / very soft mattress.
_____ I sit with my wallet in my back pocket.
_____ I cross my legs when I sit.
_____ I hold the phone with my neck.
_____ I carry a purse / bag / child usually on one side.
_____ I pop / crack my neck, back or other joints.
Females: Could You Be Pregnant? *yes / no*
Date of Last Menstrual Period: _____
If yes, Estimated Due Date: _____
Midwife / ObGyn: _____

PAST HISTORY:

Please Check All That Apply & Explain……..….
_____ Fractures: _____
_____ Dislocations: _____
_____ Head Injuries: _____
_____ Falls / Injuries: _____
_____ Car Accidents: _____
_____ Surgeries: _____
_____ Hospitalizations: _____
_____ Stroke / Heart Attack: _____
_____ Seizures / Black Outs: _____
_____ Allergies / Asthma: _____

Please List All Medical Conditions: _____
_____
_____
Significant Family History: *cancer / heart disease / stroke / diabetes / epilepsy / thyroid conditions / bleeding disorders / arthritis / allergies / asthma / other:* _____
Do You Wear A Prostheses / Pacemaker ? *yes / no*
Do You Wear Lifts / Arch Supports? *yes / no*
Have You Had Chiropractic Care Before? *yes / no*
If Yes, When Was Your Last Visit? _____
Date Of Most Recent X-rays? _____

INJURY DETAILS:

Date & Location Of Accident: _____

Your Position At Impact? *front seat – driver / front seat - passenger / back seat –left / back seat – right / other*

Where Was The Impact? *behind / front / right side / left side / other:* _____

Did Your Car Strike Anything? *yes / no* Did Anything Strike Your Car? *yes / no*

Approximately How Fast Was Your Vehicle Traveling At Impact? _____ *m.p.h.*

Approximately How Fast Was The Other Vehicle Traveling? _____ *m.p.h.*

Did You See The Accident Coming? *yes / no* If Yes, Did You Brace Yourself At Impact? *yes / no*

How Were You Seated At Time Of Impact? *facing forward / body turned left / body turned right / head turned left / head turned right / head tipped up / head tipped down / other:* _____

Where Were Your Hands & Feet At Impact? _____

Did Any Part Of Your Body Strike Anything? *yes / no* If Yes, What? _____

Did You Ever Become Unconscious? *yes / no* Did The Airbag Deploy? *yes / no*

Were You Wearing Your Seatbelt? *yes / no* Any Seat Belt Injuries? *yes / no*

Where Was The Headrest In Relation To Your Head? *below / at / above / unsure / other:* _____

Where Any Traffic Citation Issued To You? *yes / no* If Yes, What? _____

How Did The Accident Occur? (be specific) _____

_____

_____

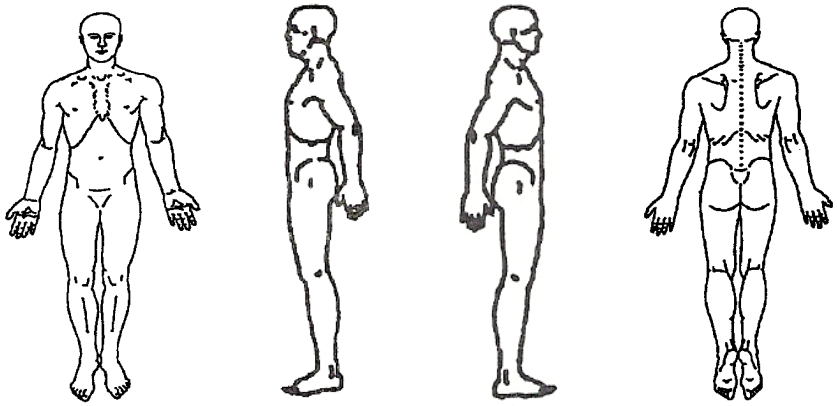
_____

_____

_____

_____

Use The Diagrams Below To Circle Where You Have Symptoms, Then Use The Descriptors To Describe Them :



Abbreviations For Descriptors:

A = Ache
BP = Burning Pain
C = Cramp
D = Dull Pain / Soreness
N = Numbness
PNS = Pins & Needles Sensation
S = Stiffness
SSP = Sharp / Stabbing Pain
T = Throbbing
TSP = Traveling / Shooting Pain
O = Other

In Addition, Have You Had Any Of The Following Since The Accident……..

tension / fatigue / light-headedness / dizziness / fainting / black-outs / nausea / irritability / nervousness / depression / loss of smell / loss of taste / loss of sensation / light sensitivity / blurred vision / sinus problems / ringing in the ears / buzzing in the ears / jaw problems / loss of memory / loss of concentration / face flushed / loss of balance / diarrhea / constipation / stomach upset / cold sweats / fever / breathing problems / chest pain / loss of strength / cold feet / cold hands / other: _____

How Soon Did The Symptoms Start? *instantly / gradually / unsure / other:* _____

Since The Accident, Have The Symptoms Been……. *getting better / getting worse / staying the same / other*

How Frequent Are Your Symptoms? *comes & goes / constant / other:* _____

Would You Say It Is Worse In The…….. *mornings / afternoons / evenings / it doesn't change / other*

Does Your Problem Vary In Intensity? *yes / no* (if yes, in the question below- give rates for those variations)

Rate Any Pain On A Scale Of 1-10 (1 = Minimal & 10 = Worst Pain Ever): _____

What Things Make The Symptoms Worse? _____

What Things Make The Symptoms Better? _____

How Has Your Life Been Affected Since The Accident? *not at all / occasionally / minimally / moderately / severely*

More Specifically, Has Any Of The Following Been Affected? *work / sleep / daily routine / driving / hobbies*

Have You Lost Any Days Of Work Because Of The Accident? *yes / no* If yes, how many? _____

What Have You Done To Help The Symptoms & What Were The Results? _____

_____

Did You Seek Medical Attention? *yes / no* If Yes, Where? _____

Have You Ever Had Any Symptoms Like This Before? *yes / no*

TO SERVE YOU BETTER:

Your health affects everything you do & everyone you know. That's why our mission at Westside Chiropractic Center, is to aid in the restoration of health by providing quality care through chiropractic, nutrition, massage & rehabilitation; so that our patients can achieve & maintain optimum health. We welcome the opportunity to help in your road back to health. Answering the questions on this form will give us a profile of the specific stresses you have faced in your lifetime, including the most recent injury, allowing us to better assess the challenges to your health potential. When a person is involved in an auto-related accident, our office follows a very specific protocol based on the protocol used by the leading authorities in the chiropractic field dealing with auto-related injuries. Of course, this varies somewhat based on the severity of your injuries. We ask that you answer a few more questions, to help us make the best choices for your care plan.

If You Have Had Chiropractic Care In The Past, What Particular Types Of Care Have You Received? *unsure / manual adjusting (using the hands) / instrument adjusting (instrument) / table assisted adjusting (table drops under you) / other:* _____

Comments: _____

_____

How Did You Find Out About Our Clinic? *yellow pages / website / advertisement / referral / other:* _____

To Whom May We Thank For Referring You? _____

AUTHORIZATION:

I, _____, have answered the following questions to the best of my ability and do hereby acknowledge that the answers I have given are completely true. I do hereby authorize the doctor at Westside Chiropractic Center to treat me for the stated personal injury and agree to comply with the doctor's management plan. If I do not comply with the recommended plan, I agree that Westside Chiropractic Center is not responsible for my outcome. I realize that I may never get back to my pre-accident status and will be treated to a point of maximum medical improvement. I agree to be responsible for all charges, regardless of the outcome of my personal injury claim. In the event that the responsible party does not compensate Westside Chiropractic Center, I will pay for such charges. If a check is issued to me, I am responsible for paying Westside Chiropractic Center the amount owed. I do hereby authorize a doctor's lien in the event that my attorney receives my settlement.

I understand the above statements and agree to the terms by signing below.

Signature: _____ Date: _____

Parent / Guardian's Signature (if minor or legally unable to consent): _____

Doctor's Signature: _____