Auto Collision Injury History – Bryn Mawr Chiropractic

Name _____ Date _____
Occupation _____ Birth Date _____
Address _____ City & Zip _____
Phone: home _____ cell _____Email _____

___Single ___Married _____ Partnered If dependent children, names & ages _____

Date, time & place of accident _____

Please describe the accident circumstances_____
_____
_____
_____
_____
Did you see impact coming?_____ Road condition (icy, slippery, dry?)_____
Did your car strike the other(s) involved or did another car strike you, or both? _____
Where was your car hit? _____
Were you the ___ the driver ___ passenger ___ pedestrian? Were you working when the accident occurred?_____
Which way was your head turned upon impact?_____Position of the head rest (up, down)?_____
Was your foot on the clutch, the brakes, or just bracing on the floor?_____
Was your seat belt on?_Y_____N_____Your shoulder strap on? Y N Did your air bag engage? Y N
Did you require hospitalization after the accident? __ yes __ no. How long were you in? _____
Have you lost any days at work? _____ How many days? _____
Did you have any days of work restriction due to this accident? _____ How many _____

My insurance company _____ Claim # _____
Address & phone where claims should be sent _____
Have you contacted an attorney for this injury? If so, Name & phone number _____

What are your primary accident related injuries & how are they affecting your work, home, and recreational life? _____
_____
_____
_____
_____

Parent/Siblings Health History: (circle) diabetes, hypoglycemia, osteoporosis, thyroid problems, arthritis, Intestinal problems, heart/stroke/circulatory problems, prostate or female problems, cancer – type, Other _____

Your health history: Please circle any of the following health problems that **you** have or have had in the past: thyroid, asthma, acid reflux or other digestive problems, high blood pressure, heart, stroke or circulatory problems, dizziness, diabetes, hypoglycemia, arthritis, osteoporosis, , prostate, PMS or other female problems, cancer(explain)___ Check if you have __ medical implants, __ pacemaker.
Other Conditions: _____
List surgeries: _____
List current medications and why you are taking them: _____
_____

Symptom Assessment

Name _____ Date _____
Underline the symptoms you believed are CAUSED BY OR AGGRAVATED and made worse by the accident that you are currently being examined for and treated in this clinic.

Head symptoms – Headaches, Loss of Memory, Lightheadness, Fainting, Eye Pain, Loss of Balance, dizziness, Loss of Hearing, Pain in the Ears, Ear Noises, Ringing in the Ears, Concussion, lights bother your eyes, Loss of Smell or Taste, Jaw Pain, Facial Pain. Other _____

Neck symptoms – Head feels heavy, Neck pain and/or soreness, Neck stiffness, Difficult or limited neck movement, Grinding sounds in neck, Muscle spasms in neck, Other _____

Upper and or Mid back symptoms – Pain between the shoulder blades, Pain in back by shoulder, Upper or mid back numbness, Upper or mid back stiffness, Upper mid back muscle spasm.

Shoulders, arms and chest symptoms – Shoulder pain, arm muscle spasm, arm pain, elbow pain, wrist pain, hand pain, finger pain, arm numbness, wrist numbness, hand numbness, finger numbness, pain radiates down arm from neck, cold hands, loss of strength in arms or hands, weak grip, chest pain, chest tightness, shortness of breath, rib pain, carpal tunnel syndrome, Other _____

Abdominal symptoms – nervous stomach, nausea, gas, constipation, diarrhea, Other _____

Lower back symptoms – painful tailbone, low back muscle spasms, low back stiffness, low back pain or soreness, low back pain aggravated by lifting, stooping, bending, coughing, lying down prolonged standing or sitting, difficulty in standing erect, low back pain that radiates to your buttock, to knee, to foot, Other _____

Leg symptoms - Hip pain, thigh and or calf muscle spasm, thigh and/or calf pain, knee pain, ankle pain, ankle instability, foot pain, toe pain, thigh or calf numbness, ankle and/or foot numbness, cold feet, loss of strength in legs or feet, Other _____

General symptoms – brain fog, depression, anxiety, fatigue, insomnia, frequent urination, loss of bowel control, nervousness, jittery, bruises, lacerations (cuts), broken bones, knocked unconscious from accider stunned, unusual mood swings.

Activities of Daily Living – How are your current accident related symptoms affecting your life – specifically your work, home, relationships, sports life, hobbies, school, etc.

_____

_____

_____

TERMS OF ACCEPTANCE

When an individual or family seeks and is accepted for chiropractic care, it is essential for all parties to be working toward the same objective.

Chiropractic has only one goal. It is important that everyone understands both the objective and the method that will be used to achieve it. This will prevent any confusion or disappointment.

Definitions:

Health: A dynamic state of wholeness in which your body can accurately perceive its constantly changing needs and respond appropriately in a timely manner. In short, *Health is the ability to adapt* to both internal and external stresses, whether they are physical, chemical, or emotional.

S**ubluxation Process:** A disruption in the normal flow of Life Energy in the nerves between the brain and the cells of the body. This causes an alteration of the normal physiology and leads to a state of "dis-ease" (the inability of the body to adapt).

Chiropractic Adjustment: the specific application of a gentle force to facilitate the body's correction of subluxation, and restore its innate healing processes so as to progressively bring about a state of health and wholeness.

We only offer to diagnosis either the subluxation process or neuro-musculoskeletal conditions. We do not offer treat any disease other then the subluxation process. However, during the course of a chiropractic assessment, if we encounter non-chiropractic or unusual findings, we will advise you. If you desire, we will recommend the services of a health care provider who specializes in that area.

OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the full outward expression of your body's innate wisdom. Our only method is the use of the specific chiropractic adjustment to reverse the subluxation process. However, we may use other procedures to help your body hold the adjustments.

I, _____have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

Therefore, I accept chiropractic care on this basis.

I also understand & agree that payment is always either prepaid or due at the time of the visit, unless other arrangements have been made, and that I am responsible for all bills incurred at this office.

_____ _____
(signature) (date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____
have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to refer me for an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle. _____

_____ _____
(signature) (date)