Welcome To Auerbach Family Chiropractic Center!

Name_____ Phone _____ Cell_____
Street Address_____ Email:_____
City_____ State_____ Zip_____ Date of Birth _____
Please Check ✔ Sex: Male_____, Female _____ Marital Status: S M W D # of Children_____
Who referred you, or how did you hear about us?_____ SS#_____

Personal & Family History: Occupation:_____ Employer:_____
Employer Address:_____ Phone:_____
Spouse's Name:_____ Employer:_____ Phone:_____

Health History:

Is this a wellness visit ____, or for a specific concern? _____ Explain:_____
Describe any health concerns, including when & how they began:_____

What area(s) of your life has this problem affected the most? Family___ Relationships___ Work___ Exercise___ Recreation___
What activity does this problem prevent you from doing, either partially or totally, that you would really like to do? _____

Are you under the care of any other doctor? Yes___ No ___ Primary Care Dr's Name:_____
If Yes, the conditions being treated for: _____
List any current Medications:_____
List any past surgeries & dates:_____
List any past accidents & dates:_____
List any x-rays in the past 2 years:_____

Chiropractic History: Have you ever been to a Chiropractor before? Yes ___ No___ If Yes, Date of Last Visit_____
Chiropractor's Name:_____ Reason for care_____

If you have had the following or if you suffer from the following: *Please Check* ✔

Condition	*Occasionally*	*Frequently*
Headache	_____	_____
Migraines	_____	_____
Neck Pain	_____	_____
Shoulder Pain	_____	_____
Arm/Hand Pain	_____	_____
Mid Back Pain	_____	_____
Low Back Pain	_____	_____
Hip Pain	_____	_____
Leg/Foot Pain	_____	_____
Jaw Pain	_____	_____
Disc Problems	_____	_____
Arthritis	_____	_____
Joint Swelling	_____	_____
Numbness	_____	_____

Condition	*Occasionally*	*Frequently*
Dizziness	_____	_____
Nausea	_____	_____
Chest Pains	_____	_____
Cough	_____	_____
Weakness	_____	_____
Fatigue	_____	_____
Nervousness	_____	_____
Insomnia	_____	_____
Vision Changes	_____	_____
Nose Bleeds	_____	_____
Ringing in Ears	_____	_____
Earaches	_____	_____
Hearing Loss	_____	_____
Frequent Colds	_____	_____

Condition	*Occasionally*	*Frequently*
Allergies	_____	_____
Asthma	_____	_____
Digestive Problems	_____	_____
Urinary Problems	_____	_____
Skin Conditions	_____	_____
Diabetes	Check if yes:	_____
Gout	Check if yes:	_____
Cancer	Check if yes:	_____
Osteoporosis	Check if yes:	_____
Hypoglycemia	Check if yes:	_____
Heart Problems	Check if yes:	_____
Lung Problems	Check if yes:	_____

Other : _____
Smoker?____ Alcohol/How Often?_____
Female Problems _____ _____
Possibly Pregnant? Yes____ No_____

Present Health Goals:

___Improve Nutrition/Eating Habits
___Weight Loss/Fat Loss
___Increase Lean Muscle Mass
___Increase Bone Density
___Reduce Stress
___Lower Cholesterol
___Lower Blood Pressure
___Start Exercising
___Look Better
___ Feel Better
___Get Off Medications
___Improve Sleep
___Improve Energy
___Improve Posture
___Improve Outlook/Happiness

On a scale of 1 to 10 with 1=Poor and 10=Excellent, please rate how well you think you're doing in the following categories:
Exercise_____ Sleep_____ Diet_____ Stress Level _____ Water Intake_____ Energy Level _____

Your Signature:_____ **Date:**_____

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Auto Accident Form

Patient Name _____ **Today's Date** ____/____/_____

Please mark your involvement in the Auto Accident: ☐ Pedestrian ☐ Driver ☐ Passenger

What are your current symptoms? ☐ Pain ☐ Numbness ☐ Stiffness ☐ Weakness

Date of Accident ____/____/_____

Patient was located: ☐ Driver ☐ Passenger- middle front ☐ Passenger- right front
☐ Passenger- left rear ☐ Passenger- middle rear ☐ Passenger -right rear

Patient Vehicle Type: ☐ Compact ☐ Mid-size ☐ Full-Size ☐ SUV ☐ Pick-up ☐ Motorcycle

Second Vehicle Type: ☐ Compact ☐ Mid-size ☐ Full-Size ☐ SUV ☐ Pick-up ☐ Motorcycle

Third Vehicle Type: ☐ Compact ☐ Mid-size ☐ Full-Size ☐ SUV ☐ Pick-up ☐ Motorcycle

Road Conditions: ☐ Clear ☐ Dark ☐ Dry ☐ Foggy ☐ Icy ☐ Wet

Road Type: ☐ Asphalt ☐ Concrete ☐ Dirt ☐ Gravel

Were you aware the accident was going to occur? ☐ Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐ No

Did your airbag deploy? ☐ Yes ☐ No

Does your car have a head rest? ☐ Yes ☐ No

What position was the head rest in? ☐ Up ☐ Middle ☐ Down

Patient's Head Position: ☐ Looking Straight Ahead ☐ Left Level ☐ Left Up ☐ Left Down
☐ Right Level ☐ Right Up ☐ Right Down ☐ Looking Up ☐ Looking Down

Accident Details

Was your car braking? ☐ Yes ☐ No **Was your car moving?** ☐ Yes ☐ No
If yes, how fast? (mph) ☐ <5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ >70

Was the second vehicle braking? ☐ Yes ☐ No **Was the second vehicle moving?** ☐ Yes ☐ No
If yes, how fast? (mph) ☐ <5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ >70

Was the third vehicle braking? ☐ Yes ☐ No **Was the third vehicle moving?** ☐ Yes ☐ No
If yes, how fast? (mph) ☐ <5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ >70

Collision Details

First Impact: ☐ hit by other vehicle ☐ hit other vehicle ☐ hit by object ☐ hit object
Impact Location: ☐ front ☐ front-right ☐ front-left ☐ left
☐ right ☐ right-rear ☐ left-rear ☐ rear ☐ top

Second Impact: ☐ hit by other vehicle ☐ hit other vehicle ☐ hit by object ☐ hit object
Impact Location: ☐ front ☐ front-right ☐ front-left ☐ left
☐ right ☐ right-rear ☐ left-rear ☐ rear ☐ top

Collision Results

Body was thrown: ☐ Forward ☐ Backward ☐ Left ☐ Right ☐ Can't Remember

Head Hit: ☐ airbag ☐ front windshield ☐ rearview mirror ☐ steering wheel
☐ dashboard ☐ back of the front seat ☐ side window/door ☐ another person's body ☐ headrest

Chest Hit: ☐ airbag ☐ steering wheel ☐ dashboard ☐ back of the front seat
☐ side window/door ☐ another person's body

Shoulders Hit: ☐ shoulder harness ☐ side window/door ☐ back of front seat ☐ another person's body

Knees Hit: ☐ steering wheel ☐ dashboard ☐ back of the front seat
☐ door panel ☐ center console ☐ another person's body

Hips Hit: ☐ steering wheel ☐ dashboard ☐ back of the front seat
☐ door panel ☐ center console ☐ another person's body

Vehicle Damage

Patient Vehicle:	☐ totaled	☐ significant damage	☐ light damage	☐ no damage
Second Vehicle:	☐ totaled	☐ significant damage	☐ light damage	☐ no damage
Third Vehicle:	☐ totaled	☐ significant damage	☐ light damage	☐ no damage

Hospitalized

Were you hospitalized? ☐ Yes ☐ No. **If yes, please answer the questions below.**

When were you hospitalized? ☐ immediately ☐ later same day ☐ next day ☐ date _____

How were you transported to the hospital? ☐ ambulance ☐ life flight ☐ private transportation

What did the hospital recommend? ☐ no instructions ☐ see this clinic ☐ see DC
☐ see own doctor ☐ see orthopedist ☐ see neurologist ☐ prescription medication
☐ other: _____

Did you have any xrays taken? ☐ Yes ☐ No
If yes, what areas? _____

Accident reported to your auto or liability insurance company? Yes / No

Name of auto or liability insurance company: _____

Telephone number: _____

Claim number: _____

Attorney: _____

Attorney telephone number: _____

Signature: _____ Date: _____