# Medical History Information

Last Name: ❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms. Marital status (circle one)

First Name: Middle Initial: Single / Mar / Div / Widow

**What Do You Prefer To Be Called?** _____

Email:_____ Birth date: / / Age: Sex:

**Newsletters and Reminder Appointments via email ok? Yes( ) No( )**

Address: City: Zip code:

Home#( ) - Cell# ( ) - Soc Security# - -

Occupation: Employer: WRK #

Insurance Name(Auto) (Health)

**Reason For Today's Visit (Chief Complaint)**

What Caused Your Condition (be as specific as possible)

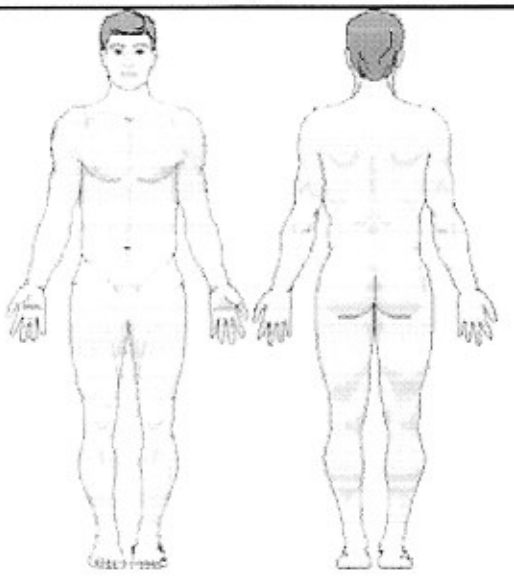
LIST AND MARK THE SEVERITY OF YOUR CONDITION ON THE SCALES BELOW:

BODY PART_____ _____

0(NONE) 5 (SEVERE) 10

BODY PART_____ _____

0(NONE) 5 (SEVERE) 10



When Did Your Condition First Appear? (Specific date, days ago, etc)

**Medical Care Information**

Do You Have a Primary Care Physician? ☐ Yes ☐ No Name of Doctor:

Address: City: State: ZIP

Date of last Visit: / / Date of last exam: / /

Have You Ever Been Treated By A Chiropractor? ☐ Yes ☐ No If Yes By Whom?_____

The Reason For The Treatment?_____ Last Visit?_____

List **ANY** Past Accidents (even if not injured) With Dates_____

Have You Ever Had Any Surgeries? ☐ Yes ☐ No If Yes, Last Surgery Date:

**FOR WOMEN ONLY**

Are you pregnant? ☐ Yes ☐ No Due Date?_____ Are you nursing?☐ Yes ☐ No

Are you taking Birth Control? ☐ Yes ☐ No 1st date of last Menstrual cycle?_____

**Your Current illness /Conditions:**

| | | | | | |
|---|---|---|---|---|---|
| ☐ AIDS | ☐ Cancer | ☐ Heart Problem | ☐ Multiple Sclerosis | ☐ Spinal Disc Disease | |
| ☐ Allergies | ☐ Cirrhosis/hepatitis | ☐ High blood pressure | ☐ Pacemaker | ☐ Thyroid trouble | ☐ Epilepsy |
| ☐ Anemia | ☐ Diabetes | ☐ HIV/ARC | ☐ Prostate trouble | ☐ Tuberculosis | ☐ |
| ☐ Arthritis | ☐ Dislocated joints | ☐ Kidney trouble | ☐ Rheumatic fever | ☐ Ulcer | ☐ |
| ☐ Asthma | ☐ Diverticulitis | ☐ Low Blood Pressure | ☐ Scoliosis | ☐ Polio | ☐ |
| ☐ Bone fracture | ☐ Hay Fever | ☐ Mental/ Emotional Difficulty | ☐ Sinus trouble | ☐ STD'S | ☐ |

Other:

**Family History of illness:** Mother/ Father/ Sister/ Brother

| | | | | | |
|---|---|---|---|---|---|
| ☐ AIDS | ☐ Cancer | ☐ Multiple Sclerosis | ☐ Spinal Disc Disease | ☐ STD'S | |
| ☐ Allergies | ☐ Bone fracture | ☐ Heart Problem | ☐ Low Blood Pressure | ☐ Sinus trouble | ☐ Ulcer |
| ☐ Anemia | ☐ Cirrhosis/hepatitis | ☐ HIV/ARC | ☐ Mental/ Emotional Difficulty | ☐ Epilepsy | ☐ Polio |
| ☐ Arthritis | ☐ Diabetes | ☐ High blood pressure | ☐ Prostate trouble | ☐ Thyroid trouble | ☐ Scoliosis |
| ☐ Asthma | ☐ Dislocated joints | ☐ Kidney trouble | ☐ Rheumatic fever | ☐ Tuberculosis | ☐ Diverticulitis |

Other:

**Social History:**

| | | | |
|---|---|---|---|
| Alcohol? ☐ No ☐ Yes Drinks per week? | Cigarettes? ☐ No ☐ Yes Packs per day? | Caffeine? ☐ No ☐ Yes Drinks per day? | Exercise? ☐ No ☐ Yes Hours per week?____ (circle one) Light / Moderate / Strenuous |

Misc.:

Are you taking any of the following medications? ☐ Anti Depressants ☐Blood Thinners ☐Tranquilizers ☐Insulin ☐Pain Killers

☐Muscle Relaxants ☐Anti-Inflammatories ☐Tylenol/Aspirin ☐Other(list please)

# Motor Vehicle Accident Information

**Date of Accident:**

Were you the ☐ Driver ☐ Front passenger ☐ Rear passenger

If a ticket was issued, to whom was it issued?_____

Number of people in your 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 your seatbelt? ☐ YES ☐ NO

Was the vehicle equipped with airbags? ☐ YES ☐ NO

If yes did they inflate? ☐ YES ☐ NO

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:

_____

Year, make and model of the vehicle you were occupying_____

Year make and model of the other vehicle_____

Did the impact come from: ☐ Front ☐ Rear ☐ Right side ☐ Left side

Were you facing: ☐ Forward ☐ Right ☐ Left

Were you: ☐ Aware or ☐ Surprised by the impact

Damage to vehicle: ☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled ☐ Unsure

Describe the accident in your own words _____

_____

## After Accident Information:

| | |
|---|---|
| **Im**mediately After Accident: | ☐ Dizzy/dazed ☐ Upset ☐ Weak ☐ Nervous ☐ Headache ☐ Disoriented ☐ Unconscious ☐/Other: |

## Medical Information (Did you get medical care for this accident before coming to our office)

| | |
|---|---|
| Medical Care? | ☐ Yes ☐ No |
| Time of care | Next day / At time of Accident / Later that Day / Days Later: (Specify) |
| Transported | Drove Self / Ambulance / Other |
| Went To | Orthopedic / Chiropractor / Neurologist / Family Doc / ER / Other:(Specify) |
| Admitted to Hospital? | ☐ Yes ☐ No Days Spent in Hospital: |
| Test: | ☐ X-ray ☐ Lab Work ☐ MRI ☐ CT Scan ☐ Other:(Specify) |
| Treatment: | ☐ Ice Pack ☐ Hot Pack ☐ None ☐ Cervical Collar ☐ Medication ☐ Other:(Specify) |

## Current Symptoms (Please note any symptoms that started after the accident occurred)

| | | | | |
|---|---|---|---|---|
| Head | ☐ Headache<br>☐ Jaw problem<br>☐ Other Specify: | ☐ Dizziness<br>☐ Loss of Memory | ☐ Blurred Vision<br>☐ Ringing/Buzzing in ear | ☐ Light Headedness<br>☐ Double Vision |
| Neck (with Movement) | ☐ Pain in Neck<br>☐ Muscle Spasms<br>☐ Other Specify: | ☐ Backward<br>☐ Bend Left | ☐ Popping in Neck | |
| Shoulders | ☐ Pain in Shoulder joint<br>☐ Pain across shoulder<br>☐ Other Specify: | ☐ Tension in shoulders<br>☐ Cant raise arms above | ☐ Muscle Spasms in Shoulder<br>[ ] Above shoulder level [ ] Over head | |
| Arms and Hands | ☐ Numbness in Left Arm<br>☐ Numbness in Right Arm<br>☐ Other Specify: | ☐ Loss of Grip Strength | ☐ Pin & needles in hands<br>☐ Pin & needles in fingers | |
| Chest | ☐ Chest pain ☐ Pain Around Ribs ☐ Other Specify: | | | |
| Abdomen | ☐ Nausea ☐ Other Specify: | | | |
| Mid back | ☐ Sharp Stabbing<br>☐ Pain in Kidney Area<br>☐ Other Specify: | ☐ Mid pain back<br>☐ Muscle Spasms | ☐ Pain From front to back<br>☐ Pain between shoulders | ☐ Dull Ache |

| | |
|---|---|
| Lower Back | ☐ Low Back Pain<br><br>Low back pain is worse when<br>☐ Working ☐ Lifting ☐ Stooping ☐ Standing ☐ Sitting<br>☐ Bending ☐ Coughing ☐ Lying Down ☐ Muscle Spasms ☐ Rising from sitting<br><br>☐ Other Specify: |
| Hips, Legs & Feet | ☐ Pain in Buttocks ☐ Pain and needles in Legs ☐ Pain down leg<br>☐ Pain in hip joint ☐ Swollen Feet ☐ Numbness in Toes<br>☐ Numbness of Leg ☐ Knee pain ☐ Leg cramps ☐ Cramps in Feet<br>☐ Other Specify: |
| General | ☐ Nervousness ☐ Irritable ☐ Generally Feel Rundown<br><br>Loss of Sleep : [_____] hrs per night<br><br>Loss of weight : [_____]lbs<br><br>Gain weight : [_____] ibs<br><br>Other: |

Is your condition getting worse? ☐ Yes ☐ NO ☐ Constant ☐ Comes and goes

Have you missed any work because of this accident? ☐ Yes ☐ NO If so dates_____

## Previous Injuries

| | |
|---|---|
| Previous Injuries / Accidents | ☐ No ☐ Yes, Specify: |
| Residual pain from Previous Injuries/Accidents | ☐ No ☐ Yes, Specify: |

Have you retained an attorney? ☐ Yes ☐ No If yes, whom:_____

PH#_____

I_____ hereby request that you, my attorney provide Dr. William I. Lichter's office with a Letter Of Protection.

Signature: _____Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.