Automobile Accident Questionnaire

Patient Name: _____ Date: _____

Date of the accident: _____ You were: ☐ Driver ☐ Front Seat ☐ Passenger Back Seat

You : ☐ Struck another vehicle ☐ Struck by another vehicle ☐ Was struck by and caused to strike another vehicle

Where was the impact to your vehicle? ☐ Behind ☐ Front ☐ Left Side ☐ Right Side

Were you wearing a seatbelt? ☐ Yes ☐ No

At the time of impact your vehicle was: ☐ Stopped ☐ In motion

Was there anyone else in your vehicle? ☐ Yes ☐ No Was anyone else injured? ☐ Yes ☐ No

At the time of impact you were: ☐ Head faced forward ☐ Head turned left ☐ Head turned right

Did any part of your body hit any part of the car during impact? ☐ Yes ☐ No If so what part: _____

Did you feel pain immediately after the impact? ☐ Yes ☐ No If so, where was your pain: _____

Were you taken to the hospital: ☐ Yes ☐ No Hospital: _____

Were any X-Rays taken? ☐ Yes ☐ No Treatment received: _____

Have you missed any work as a result of the accident? ☐ Yes ☐ No If so, number of days missed? _____

Were you working when this accident happened? ☐ Yes ☐ No If so, has a worker's Comp claim been filed? ☐ Yes No

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Have you retained an attorney? ☐ Yes ☐ No Not yet

If an attorney has been retained, please provide us with name address and phone number: _____

_____

Name of the driver of the ***other*** vehicle: _____

Auto Insurance company name : _____ Policy # _____

Claim adjustor name: _____ Claim # _____

Phone # _____

Name of the driver of the car ***you were*** in: _____

Auto Insurance company name: _____ Policy # _____

Is there ***Med Pay*** on this policy? _____ Amount $ _____

Claim adjustor name: _____ Claim # _____

Phone # _____

Were the police notified: ☐ Yes ☐ No ⟹ If so please provide us with a copy of the report.

Signature: _____ Date: _____

Patient Health Questionnaire

Patient Name_____ **Date**_____

1. Describe your current symptoms (Begin with what bothers you the most): _____

_____

2. Do your symptoms radiate (travel)? □ Yes □ No If yes, to what part of your body? _____

3. How long have your symptoms been present? _____

4. When is it most noticeable? □ Upon Waking □ During the day □ Afternoon □ Evening □ While Trying to sleep

_____

5. What activities make your symptoms worse? □ Ice □ Rest □ Sitting □ Medication
□ Heat □ Activity □ Standing □ _____

_____

6. What activities make your symptoms better? □ Ice □ Rest □ Sitting □ Medication
□ Heat □ Activity □ Standing □ _____

7. What describes the nature of your symptoms?

□ Sharp □ Shooting
□ Dull Ache □ Burning
□ Numb □ Tingling

_____

8. How often are your symptoms present?

□ Occasional (0-25%) □ Frequent (50-75%)
□ Intermittent (25-50%) □ Constant (75-100%)

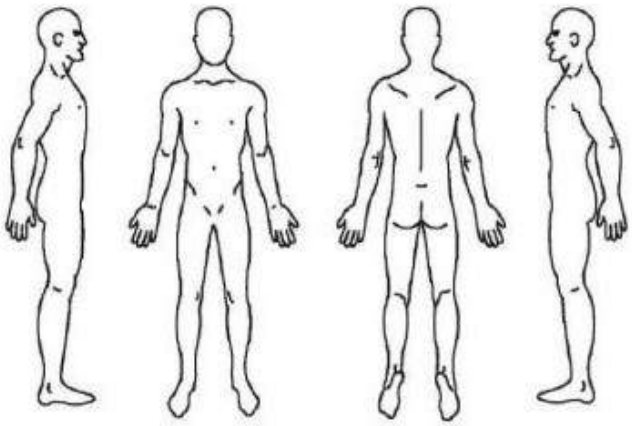
_____

9. How are your symptoms changing?

□ Getting Better
□ Not Changing
□ Getting Worse

_____

Indicate where you have pain or other symptoms



10. Who else have you seen for your current symptoms?

□ No One □ Medical Doctor □ This Office
Provider's name: _____ □ Other Chiropractor □ Physical Therapist □ _____

_____

11. What tests have you had for your symptoms? □ None □ MRI date: _____
□ X-rays date :_____ □ CT Scan date: _____

_____

12. What describes the severity of your symptoms? **None 1 2 3 4 5 6 7 8 9 10 Severe**

_____

13. What other forms of care have you tried for your current complaint?

□ Nothing □ Muscle Relaxer □ Advil / Tylenol / Aleve (circle) □ Injections
□ Pain Medication □ Ice / Heat (circle) □ Physical Therapy □ Other_____

_____

14. What do you feel caused your symptoms? □ Fall □ Lifting □ Work
□ Car Accident □ Don't Know □ _____

_____

15.What activities are affected by your symptoms?

□ Work/School (circle) □ Sleeping □ Driving/Riding in Car (circle) □ Golf □ Exercising
□ Walking □ Running □ House Work □ Yard Work □ _____

_____

LE: CL:

For each of the conditions listed below, place a check in the* PAST *column if you have had the condition in the past.

Place a check in the* PRESENT *column if you currently have the conditions listed.

Many of the following conditions respond to chiropractic and acupuncture

16. 17.

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT	
( )	( )	Headaches	( )	( )	High Blood Pressure	( )	( )	Diabetes
( )	( )	Neck Pain	( )	( )	Low Blood Pressure	( )	( )	Excessive Thirst
( )	( )	Upper Back Pain	( )	( )	High Cholesterol	( )	( )	Excessive Urination
( )	( )	Mid Back Pain	( )	( )	Heart Attack	( )	( )	Hypo-Thyroid
( )	( )	Low Back Pain	( )	( )	Chest Pains	( )	( )	Hyper-Thyroid
( )	( )	Scoliosis	( )	( )	Stroke	( )	( )	Smoking/Tobacco Use
( )	( )	Shoulder Pain	( )	( )	Angina	( )	( )	Drug/Opioid Dependence
( )	( )	Elbow Pain				( )	( )	Alcohol Dependence
( )	( )	Wrist Pain	( )	( )	Kidney Stones			
( )	( )	Hand Pain	( )	( )	Kidney Disorder	( )	( )	Food Allergies
			( )	( )	Bladder Infection	( )	( )	Depression
( )	( )	Hip Pain	( )	( )	Painful Urination	( )	( )	Anxiety
( )	( )	Knee Pain	( )	( )	Loss of Bladder Control	( )	( )	Frequent Illness
( )	( )	Ankle Pain	( )	( )	Prostate Problems	( )	( )	Epilepsy
( )	( )	Foot Pain	( )	( )	Dermatitis			
			( )	( )	Reflux/Heartburn	( )	( )	Eczema
( )	( )	Jaw Pain/TMJ	( )	( )	Abnormal Weight Gain	( )	( )	Poison Ivy/Oak
			( )	( )	Abnormal Weight Loss	( )	( )	HIV/AIDS
( )	( )	Joint Swelling/Stiffness	( )	( )	Loss of Appetite			
( )	( )	Arthritis	( )	( )	Constipation	***Females Only***		
( )	( )	Rheumatoid Arthritis	( )	( )	Abdominal Pain			
			( )	( )	Ulcer	( )	( )	Hot Flashes
			( )	( )	Hepatitis	( )	( )	Hormone Replacement
( )	( )	General Fatigue	( )	( )	Liver Disorder	( )	( )	Birth Control Pills
( )	( )	Ringing in Ears	( )	( )	Gall Bladder Disorder	( )	( )	Painful Periods/Cramps
( )	( )	Visual Disturbances						
( )	( )	Dizziness	( )	( )	Cancer	YES	NO	Are You Pregnant?
( )	( )	Nausea	( )	( )	Tumor			
			( )	( )	Asthma			
			( )	( )	Chronic Sinusitis			
			( )	( )	Seasonal Allergies			

18. Primary Care Physician_____ **18b. Date of Last Medical Physical**_____

19. Indicate if an immediate family member has had any of the following:

(1) Rheumatoid Arthritis (2) Heart Problems (3) Diabetes (4) Cancer (5) Lupus (6) Other: _____

20. List all prescription and over-the-counter medications, nutritional/herbal supplements you are taking:

_____

21. List all the surgical procedures you have had AND times you have been hospitalized (INLCUDING GIVING BIRTH):

_____

_____

22. <u>ANY & ALL LIFETIME TRAUMA HISTORY</u> to head, neck, or back (such as concussion, automobile accidents, sports injuries, work-related accidents, etc)...EVEN IF YOU DID NOT HAVE ANY SYMPTOMS OR TREATMENT, STILL NOTE THE TRAUMA PLEASE.

_____

_____

Patient Signature_____ ***Date***_____

Patient Introduction Card

Today's Date _____ Account #_____

Full Legal Name _____ Prefer To Be Called_____

Home Address_____ Occupation_____

City_____ State_____ Zip_____ Employer_____

Home Phone_____ Name of Insurance Co_____

Cell Phone_____ ***Provider***_____ Policy Holder Name _____

Work Phone_____ Policy Holder Date of Birth _____

Email_____ Primary Care Doctor_____

Date of Birth_____ Age_____ Previous Chiropractic Care? ☐ YES ☐ NO

☐ Married ☐ Single ☐ Other_____ Major Complaint Today_____

Social Security #_____ _____

Preferred method of contact for appointment reminders ☐ Phone ☐ Email ☐ Either is fine

Who (or what source) referred you to our office? _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged