# Accident and Injury Update

## Patient Information

Thank you for choosing Goffstown Chiropractic Care, PLLC for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help.

*(please print clearly)*

Name: ______________________________ Social security number: ____________________

Address: ______________________ City: ______________ State: _____ Zip code: __________

Sex: ❑ Female ❑ Male Date of birth: ____________ E-mail: ______________________

Home phone: (______)______________ Cell phone: (_____)______________ Work phone: (_____)______________

I prefer to receive appointment reminders via: ❑ E-mail ❑ Cell phone text – my carrier is ________________

❑ Married ❑ Widow(er) ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered for _____ years

Patient employer/school: ______________________ Occupation: ____________________

Employer/school address: ____________________ City: ____________ State: _____ Zip code: __________

Spouse or parent's name: ________________ Employer: ____________ Work phone: (_____)__________

Person to contact in case of emergency: ____________________________ Phone: (_____)__________

## Responsible Party

Name of person responsible for this account: __________________ Social security number: ______________

Relationship to patient: ________________________________ Phone: (_____)______________

Address: ______________________ City: ______________ State: _____ Zip code: __________

## Insurance Information

Insurance company name: ________________________________ Phone: (_____)______________

Name of insured person (if other than patient): ______________________ Their date of birth: ____________

Relationship of insured to patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insurance policy: ❑ Automobile ❑ Worker's compensation

Claim number: ________________________ Date of accident or injury: ____________

Name of insurance case worker: ______________________ Phone: (_____)______________

Accident/injury is related to: ❑ Employment ❑ Automobile ❑ Other ______________

## Symptoms

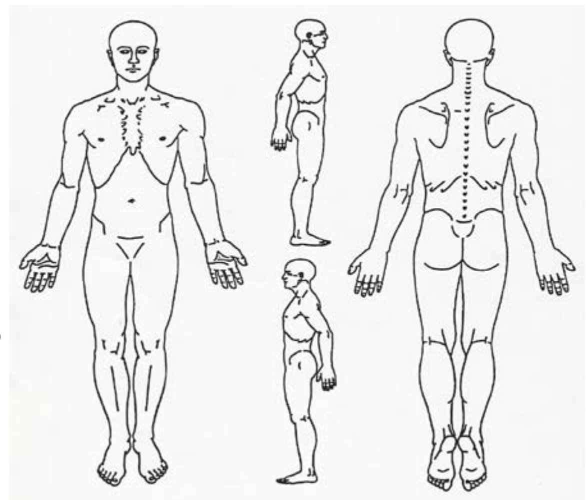
Reason for visit: ______________________________

When did you first notice your symptoms? ______________

How do you think your symptoms began? ______________

______________________________________________

Indicate on the drawings to the right where you have pain/symptoms:



How often do you experience your symptoms?

❑ Constantly (76-100% of the time) ❑ Frequently (51-75% of the time)
❑ Occasionally (26-50% of the time) ❑ Infrequently (1-25% of the time)

How are your symptoms changing with time?

❑ Getting worse ❑ Staying the same ❑ Getting better

## *Symptoms, continued*

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Achiness ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other: ___________________

Rate the severity of your pain. (1 = mild pain or discomfort, to 10 = severe pain) 1 2 3 4 5 6 7 8 9 10

What aggravates your condition? ___________________________________________

What makes your condition better? ___________________________________________

What treatment have you received for your condition?

❑ Medication ❑ Surgery ❑ Chiropractic ❑ Physical therapy ❑ Massage ❑ None ❑ Other ___________________

How much has your condition interfered with your work and social activities?

❑ Not at all ❑ A little bit ❑ Moderately ❑ Quite a bit ❑ Extremely

Do you consider your condition to be severe? ❑ Yes ❑ Yes, at times ❑ No

What concerns you the most about your condition? What does it prevent you from doing? ___________________

## *Motor Vehicle Accident* *(if applicable)*

Date of accident: ___________________ Time of accident: ___________________

How and where did the accident happen? ___________________________________________

Where were you sitting at the time of the accident? ___________________________________________

Please mark the following that apply at the time of the accident:

❑ Wearing seat belt ❑ Air bag deployed ❑ Body hit interior of car ❑ Ejected from vehicle ❑ Lost consciousness
❑ Unaware of impending collision ❑ Aware of impending collision and relaxed ❑ Aware of impending collision and tightened up

What happened after the accident?

❑ Police arrived ❑ Ambulance arrived ❑ Taken by ambulance to hospital ❑ Police report written
❑ Refused treatment ❑ Drove to hospital ❑ Went to doctor's office ❑ Other: ___________________

Immediately after the accident, where did you feel pain/symptoms? ___________________________________________

Currently where do you feel pain/symptoms? ___________________________________________

Other treatment received for this accident: ___________________________________________

## *Worker's Compensation Injury* *(if applicable)*

Date of injury: ___________________ Time of injury: ___________________

How and where did the injury happen? ___________________________________________

What happened after the injury?

❑ Continued working ❑ Stopped working ❑ Notified supervisor ❑ Incident report written
❑ Drove to hospital ❑ Went to doctor's office ❑ Received no treatment ❑ Other: ___________________

Immediately after the injury, where did you feel pain/symptoms? ___________________________________________

Currently where do you feel pain/symptoms? ___________________________________________

Are you currently working? ❑ Yes, without restrictions ❑ Yes, with restrictions ❑ No

Other treatment received for this injury: ___________________________________________

## *Patient Payment Agreement*

Our policy requires payment in full for all services rendered at the time of your visit, unless other arrangements have been made with the doctor. I understand the above information and guarantee this form was completed correctly and to the best of my knowledge, and I understand it is my responsibility to inform this office of any changes to my health record.

Signature ___________________________________________ Date ___________________