

Incident & Injury Information

Date: _____ DOI: _____
Name: _____ Age: _____ DOB: _____ Height: _____ Weight: _____
Handedness: R / L / A: Race: _____ Occupation: _____ FT / PT
Type of Injury: Auto Work Personal Sports Other: _____ Time: _____ AM/PM
Were others involved? Yes No if yes Names: _____
Please describe the incident in your own words: _____

IF INJURY INVOLVED A VEHICLE (IF NOT SKIP TO HEAD POSITION)

Were you the driver Passenger Front Seat Back Seat Other
Year and Model of your vehicle: _____ People in your vehicle: _____
What direction were you traveling? N / S / E / W Street: _____
Were you stopped? Yes / No. If no, your Est. speed: _____ Struck from the F / R / P / D
Year and model of other vehicle(s): _____
Direction of other vehicle(s): N / S / E / W Street: _____
Were they stopped? Yes / No. If no, their Est. speed: _____ Struck from the F / R / P / D

Road Conditions? Wet Dry Visibility? Good Poor Wearing a seat belt? Yes No
With shoulder harness? Yes No Were you aware of the impending collision? Yes No
If yes, did you brace and how? _____ Did the air bags deploy? Yes No
Were the police notified? Yes No If yes, was a report filed? Yes No

HEAD POSITION

Your head position at injury? _____ Did you lose consciousness? Yes No If yes,
Please explain: _____

Were you taken anywhere by ambulance or private party? Yes No If yes, please explain any testing,
medications and/or treatment you received: _____

How did you feel immediately following the incident? _____

How did you feel later that day? _____

How did you feel the next day? _____

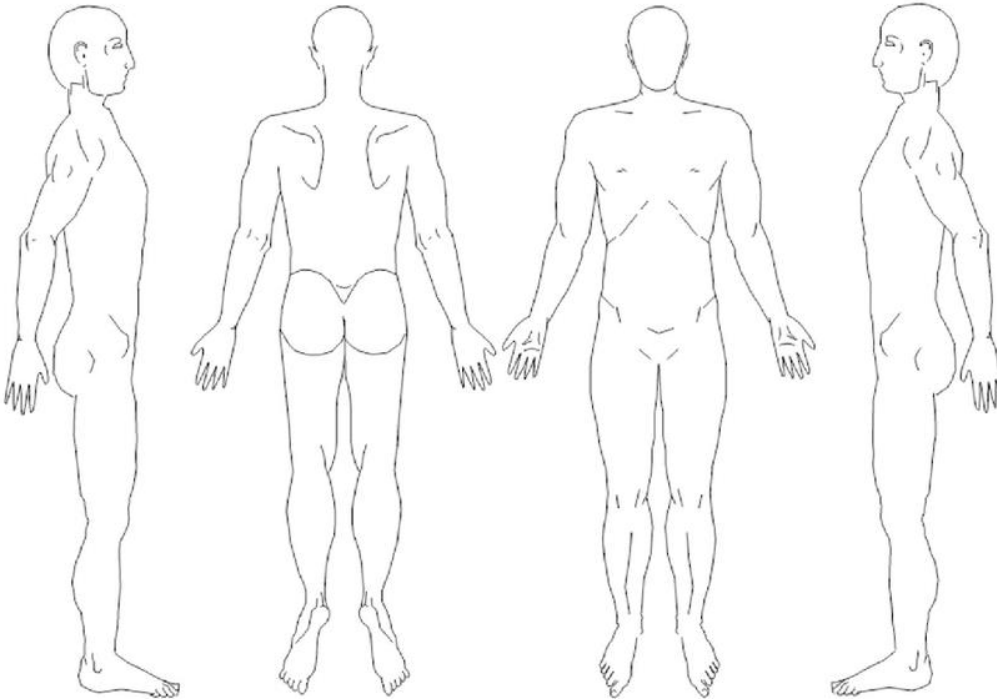
How did you feel the following days? _____

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Please mark all areas of pain on the diagrams below:



Please list your current health concerns related to your injuries in order of priority: _____

Did your injuries occur while performing your job duties? Yes No If yes, please explain: _____

Has your condition impaired performing your job duties? Yes No If yes, please explain: _____

Have you lost time from work as a result of your injuries? Yes No If yes, please explain: _____

How do these conditions impair your daily activities? _____

How do these conditions impair your social activities? _____

What makes your condition better? _____

What makes your condition worse? _____

Anything else you would like to share? _____

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Did you have any health complaints prior to your injuries?

Yes No If yes, please explain:

Have you ever had your current injuries before this incident?

Yes No If yes, please explain:

If you have experienced any of the following conditions in the past, please mark (P) on the line provided.

If you are currently experiencing any of the following conditions, please mark (C) on the line provided.

____ Heart Attack

____ Ringing in Ears

____ Unexplained Weight Loss

____ Stroke

____ Asthma

____ Unexplained Weight Gain

____ High BP

____ Diarrhea

____ Recent Fever/Sweats

____ Diabetes

____ Constipation

____ Chest Pain/Discomfort

____ Cancer

____ Trouble Swallowing

____ Palpitations

____ Arthritis

____ Indigestion/Reflux

____ Shortness of Breath

____ Kidney Stones

____ Abdominal Pain

____ Anxiety/Stress

____ Gall bladder

____ Difficulty W/ Urination

____ Sleep Problems

____ Prostate Problems

____ Blood in Urine

____ Coughing/Wheezing

____ Nausea/Vomiting

____ Blood in Stool

____ Change in Vision

____ Dizziness

____ Gout

____ Glaucoma

____ Headache

____ Muscle Pain

____ Cold/Heat Intolerance

____ Memory Loss

____ Joint Replacement

____ Increased Thirst

____ Fainting

____ Joint Pain

____ Hearing Loss

____ Unexplained Fatigue

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patients Signature: _____ Date: _____

Guardians Signature: _____ Date: _____

Incident & Injury Information

Name: _____

DOB: _____

Place a check on the line in the first (1st) column if you had any of these symptoms before the collision.
 Place a check on the line in the second (2nd) column if you had any of these symptoms after the collision.
 Place a check on the line in the third (3rd) column if you are experiencing any of these symptoms today.
 Please leave the last column blank (for office use only)

	Before DOI	After DOI	Today	Today 0/10
Difficulty with Thinking/Remembering				
Thinking Clearly	_____	_____	_____	_____
Concentration, focus, and/or organization	_____	_____	_____	_____
Memory	_____	_____	_____	_____
Reading/Comprehension	_____	_____	_____	_____
Loss of insight and/or poor judgment	_____	_____	_____	_____
Difficulty with Sleep				
Sleeping more than usual/less than usual	_____	_____	_____	_____
Falling asleep/Staying asleep	_____	_____	_____	_____
Mental and/or Physical Fatigue	_____	_____	_____	_____
Physical				
Headache	_____	_____	_____	_____
Fuzzy, blurry and/or double vision	_____	_____	_____	_____
Nausea and/or vomiting	_____	_____	_____	_____
Dizziness and/or light-headed	_____	_____	_____	_____
Balance problems / feelings of falling and/or spinning	_____	_____	_____	_____
Difficulty speaking and/or writing	_____	_____	_____	_____
Decrease or loss of smell/taste	_____	_____	_____	_____
Sensitivity to noise, and/or light	_____	_____	_____	_____
Emotion, Mood and Affect				
Feeling more emotional and/or emotionally fragile	_____	_____	_____	_____
Feeling nervous/restless and/or anxious	_____	_____	_____	_____
Feeling irritable/frustrated and/or impatient/angry	_____	_____	_____	_____
Feeling apathetic and/or without motivation	_____	_____	_____	_____
Feeling depressed, sad and/or tearful	_____	_____	_____	_____
Personality changes	_____	_____	_____	_____
Neglecting personal hygiene	_____	_____	_____	_____
Socially inappropriate behavior	_____	_____	_____	_____
Unusual sexual behavior and/or loss of libido	_____	_____	_____	_____

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 Please leave the last column blank (for office use only)

	Before DOI	After DOI	Today	Today 0/10
Head, Face, and Neck Pain:				
Headache – Right / Left	_____	_____	_____	_____
Face – Right / Left	_____	_____	_____	_____
Upper Neck – Right / Left / Midline	_____	_____	_____	_____
Lower Neck – Right / Left / Midline	_____	_____	_____	_____
Back Pain:				
Upper Back – Right / Left / Midline	_____	_____	_____	_____
Middle Back – Right / Left / Midline	_____	_____	_____	_____
Lower Back – Right / Left / Midline	_____	_____	_____	_____
Pelvis – Right / Left / Midline	_____	_____	_____	_____
Upper Body Pain:				
Shoulders - Right / Left / Front / Back	_____	_____	_____	_____
Arms - Right / Left	_____	_____	_____	_____
Hands - Right / Left	_____	_____	_____	_____
Fingers - Right / Left	_____	_____	_____	_____
Lower Body Pain:				
Hips - Right / Left	_____	_____	_____	_____
Thighs - Right / Left	_____	_____	_____	_____
Legs - Right / Left	_____	_____	_____	_____
Feet - Right / Left	_____	_____	_____	_____

Are you experiencing any other difficulties?

1. _____
2. _____

Thank you for taking the time to fill out this form as completely as possible. Successful healthcare preventative medicine is only possible when the practitioner has a complete understanding of the patients physical, mental, and emotional state.

Confidential Patient Information

First Name: _____ Last Name: _____ DOB: _____
Phone: _____ Email: _____ SSN: _____
Gender: M / F / Other Handedness: R / L / A Referred by: _____
Address: _____ Apt# _____ City: _____ State: _____ Zip: _____
Employer: _____ Occupation: _____
Work Address: _____ City: _____
State: _____ Zip: _____ Work Phone: _____ Ext: _____
Marital Status: Single Married Divorced Widowed Spouse: _____
Emergency Contact: _____ Phone: _____

Claim Information

Cause: Auto Accident Personal Injury Work Injury Sports Injury Other: _____
Type of Claim: Auto Accident Personal Injury Work Injury Sports Injury Other: _____
Insurance Name: _____ Claim# _____
Address: _____ City: _____ State: _____ Zip: _____
Adjuster: _____ Phone: _____ Fax: _____

Group Health Insurance

Relationship to the insured: Self Spouse Child Other: _____
Insured's Employer (Same as Above) Other: _____ Insured's SS# (Same as Above)
Other SS# _____ Insured's DOB: (Same as Above) Other DOB: _____
Primary Insurance Co. _____ Address: _____
City: _____ State: _____ Zip Code: _____ Phone: _____ Ext: _____
Secondary Insurance Co. _____ Address: _____
City: _____ State: _____ Zip Code: _____ Phone: _____ Ext: _____

Attorney Information

Attorney Name: _____ Address: _____
City: _____ State: _____ Zip Code: _____ Phone: _____ Ext: _____

Authorizations:

- A. I hereby authorize the release of any medical information necessary to process this claim and request payment of insurance benefits to either myself or to the party who accepts assignment. Additionally, I hereby authorize release of any medical information to any third party as I deem necessary for my medical benefit.
- B. I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe to this office by my attorney, out of the proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and/or services rendered.
- C. I Understand and agree that health and accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection form the insurance company, and that any amount authorized to be paid directly to this office will be credited to my account upon receipt.
- D. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Signature: _____ Date: _____