## **Accident Chiropractic**

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## **INSURANCE INFORMATION**

## PATIENT INFORMATION

Today's Date	Driver of Vehicle you were in:
	Driver's Insurance Policy:
Name:	Driver's Policy #?
Address:  City: State: Zip:	Driver's Claim #?
City: State. Birthdate:	Other Vehicles Insurance:
Sex: M F Age: Birthdate:  Cell #: Work#_	Claim#:
Cell #:Wolk#	and the state of t
Email:	
SS#	Health Insurance
Occup. & Employer:	Nome
Family Dr. Name & #	ID # Phone #
	Phone #
Where did you hear from us?	
	Check if you would like to be notified of your next
	Appointment by either text or email
Radio:	
T.V.:	
	The second of th
Is this condition due to an accident? Yes No Date of accident Place: Where you the o driver of front passenger	Does it interfere with your: Owork Osleep ORecreation Obaily Activities Other: Movements that are painful Ositting Ostanding OBending Owalking OTwisting OLaying Down
o rear passenger o pedestrian  Hit from o rear o front o driver side o passenger side  How many people were in the vehicle?	Other:  Have you had any of the following since the accident?  Shoulder Chest Pain Dizziness
Were you wearing a seatbelt? o yes o no	oBack Pain oFatigue oAnxiety oBack Stiffness oHard to Sleep oDepression
Did an airbag deploy? o yes o no	o Back Stiffness o Hard to Sleep o Depression
Did any part of your body strike anything in	oNeck Pain oBlurred Vision oIrritability
the vehicle? o yes o no what?	oNeck Stiffness oMemory Loss
Did you lose consciousness? o yes o no	oMuscle Soreness OAvoid Loud Sounds
Did you go to the hospital? o yes o no	
Intr Jon to m me motive.	oHeadaches oAvoid Bright Light
Which hospital?	oHeadaches oAvoid Bright Light oArm/Hand Numb oArm/Hand Tingle oArm Pain
Which hospital?	oHeadaches oAvoid Bright Light oArm/Hand Numb oArm/Hand Tingle oArm Pain oLeg/Foot Numb oLeg/Foot Tingle oLeg Pain
Which hospital?When did you go? oImmediately oOther	oHeadaches
Which hospital? When did you go? oImmediately oOther Did you go by ambulance? o yes o no	oHeadaches oAvoid Bright Light oArm/Hand Numb oArm/Hand Tingle oArm Pain oLeg/Foot Numb oLeg/Foot Tingle oLeg Pain
Which hospital? When did you go? oImmediately oOther Did you go by ambulance? o yes o no Were X-rays taken? o yes o no	oHeadaches oAvoid Bright Light oArm/Hand Numb oArm/Hand Tingle oArm Pain oLeg/Foot Numb oLeg/Foot Tingle oLeg Pain oKnee Pain oHip Pain oWrist/Elbov Your Attorney Name & Phone
Which hospital? When did you go? oImmediately oOther Did you go by ambulance? o yes o no Were X-rays taken? o yes o no Medications given? o yes o no	oHeadaches oAvoid Bright Light oArm/Hand Numb oArm/Hand Tingle oArm Pain oLeg/Foot Numb oLeg/Foot Tingle oLeg Pain oKnee Pain oHip Pain oWrist/Elbov Your Attorney Name & Phone
Which hospital? When did you go? oImmediately oOther Did you go by ambulance? o yes o no Were X-rays taken? o yes o no Medications given? o yes o no Have you worked since the accident? o yes o no	oHeadaches oAvoid Bright Light oArm/Hand Numb oArm/Hand Tingle oArm Pain oLeg/Foot Numb oLeg/Foot Tingle oLeg Pain oKnee Pain oHip Pain oWrist/Elbow Your Attorney Name & Phone  Do you or someone in your house own a a car?
Which hospital? When did you go? oImmediately oOther Did you go by ambulance? o yes o no Were X-rays taken? o yes o no Medications given? o yes o no Have you worked since the accident? o yes o no Have you had any prior accidents? o yes o no	oHeadaches oAvoid Bright Light oArm/Hand Numb oArm/Hand Tingle oArm Pain oLeg/Foot Numb oLeg/Foot Tingle oLeg Pain oKnee Pain oHip Pain oWrist/Elbov Your Attorney Name & Phone
Which hospital? When did you go? oImmediately oOther Did you go by ambulance? o yes o no Were X-rays taken? o yes o no Medications given? o yes o no Have you worked since the accident? o yes o no	oHeadaches oAvoid Bright Light oArm/Hand Numb oArm/Hand Tingle oArm Pain oLeg/Foot Numb oLeg/Foot Tingle oLeg Pain oKnee Pain oHip Pain oWrist/Elbov Your Attorney Name & Phone  Do you or someone in your house own a a car? o yes o no

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hat treatment have you already	received for your condition? ol	viedication • Surgery
Physical Therapy • Chiropra	ctic Services O None O Other:_	
ame and phone # of other docto	ors seen:	mes?
ave you had any of the following	ng pulmonary (lung-related) iss COPD • Emphysema • Other	○ None of the abo
Asthma/difficulty breating	ng cardiovascular (heart-related	
Heart attacks/MIs O Heart dis	ease/problems o Hypertension o	Pacemaker Other
ive you had any of the following	ng neurological (nerve-related)	issues?
Visual changes/loss of vision	One-sided weakness of face or	body O Seizures O Headaches
Memory loss o Tremors o Ve	ertigo O Strokes/TIAs O Other	
eve you had any of the following	ng endocrine (glandular/hormo	nal) related issues or procedures?
Thyroid disease O Hormone R	Replacement Therapy O Diabetes	Other
eve you had any of the following	ng renal (kidney-related) issues	or procedures?
Blood in Urine O Incontinence	e (can't control) o Bladder Infect	ions • Other
eve you had any of the following	ng gastroenterological (stomach	-related) issues?
Nausea O Difficulty Swallowi	ng O Ulcers O Frequent Abdomi	nal Pain O Hiatal Hernia O Constipati
Liver Disease O Bloody Stool	s O Vomiting Blood O Bowel Inc	continence Other
eve you had any of the following	ng hematological (blood related	) issues?
Anemia O Regular Anti-inflan	nmatory use (Motrin/Ibuproten/N	aproxen/Naprosyn/Aleve) OHIV Posi
Hemophilia O Anticoagulant	Inerapy O History of Blood Clots	icano 2
eve you had any of the following	ng dermatological (skin-related)	issues?
Significant Burns O Significan	ng <b>dermatological (skin-related</b> ) nt Rashes      Skin Grafts      Psoria	tic Disorders Other
ave you had any of the following Significant Burns o Significant ave you had any of the following ave	ng dermatological (skin-related) nt Rashes	tic Disorders Othere-related) issues?
ave you had any of the following Significant Burns o Significant ave you had any of the following Arthritis o Gout o Spinal Frac	ng dermatological (skin-related) nt Rashes • Skin Grafts • Psoria ng musculoskeletal (bone/musch ture • Spinal Surgery • Scolios	tic Disorders Othere-related) issues?
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rve you had any of the following Significant Burns of Significant Burns of Significant Burns of the following Arthritis of Gout of Spinal Fractive you had any of the following Psychiatric Diagnosis of Depresentation Diagnosis of Depresentation Diagnosis of Depresentation Disease of Arthritis of Neurological Disease of Bleeding Disorders  Exercise of Moderate of Daily of Heavy	og dermatological (skin-related) at Rashes Oskin Grafts OPsoria ag musculoskeletal (bone/musch ature Ospinal Surgery Oscolios ag psychological issues? assion Osipolar Disorder Oschi  Ostroke / TIAs Omigrane Headaches Obteoporosis Other  Work Level Ositting Ostanding	issues? tic Disorders Other -related) issues? is OMetal Implants Other  zophrenia Other  Social History  Job Description: Recreational Activities:  Habits OSmoking OAlcohol Coffee/Caffeine High Stress
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