PATIENT INFORMATION SHEET

☐ **Private** ☐ **Medicare** ☐ **Personal Injury**
☐ **Private Insurance** ☐ **Work Comp.** ☐ **QME**

TODAY'S DATE: _____ **DATE(S) OF INJURY:** _____

PATIENT: Last Name _____ First Name _____ Middle Name _____

HOME ADDRESS: Street _____ Apt. # _____

City _____ State _____ Zip _____

HOME PHONE: (___) _____ **WORK PHONE:** (___) _____ **CELL:** (___) _____

DRIVER'S LIC. NO: _____ **SEX: M** ☐ **F** ☐ **AGE:** _____

BIRTH DATE: _____ **SOC. SEC. NO.:** _____

MARITAL STATUS: Married ☐ **Single** ☐ **Widowed** ☐ **Divorced** ☐

SPOUSE/GUARDIAN NAME: _____ **ADDRESS:** _____

IN CASE OF EMERGENCY PLEASE NOTIFY *(Person not living in your household):*

Last Name: _____ **First Name:** _____ **Phone:** (___) _____

Address: _____

EMPLOYER AT TIME OF INJURY: _____ **PHONE:** (___) _____
ADDRESS: _____

CURRENT EMPLOYER: _____ **PHONE:** (___) _____
ADDRESS: _____

PRIVATE HEALTH INSURANCE CO. (Must include name AND address) : _____

ADDRESS: _____
POLICY NO.: _____ **GROUP:** _____
SUBSCRIBER/RELATIONSHIP: _____

AUTO INSURANCE COVERAGE: _____ **PHONE:** (___) _____

ADDRESS: _____
POLICY NO.: _____ **SUBSCRIBER/RELATIONSHIP:** _____

Please read and sign the following:
I directly assign all chiropractic, medical benefits to _____. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

Signature: _____ **Date**: _____

NAME OF PATIENT: _____

SEX: (☐) **Male** (☐) **Female** (☐) **Right-Handed** (☐) **Left-Handed**

OCCUPATION: _____ **BREIF JOB DESCRIPTION:** _____

History of Current Trauma

NATURE OF ACCIDENT:

(☐) **Motor Vehicle** (☐) **Slip and Fall** (☐) **Pedestrian** (☐) **Work Related** (☐) **Other (Explain)** _____

If Non-Motor Vehicle Accident, describe the injury: _____

_____

_____

MotorVehicle Accident Information Only:

Patient was the: (☐) **Driver** (☐) **Passenger in the…** (☐) **right front seat** (☐) **rear** (*circle one* middle left right seat) (☐) **bed of Pickup**

Patient was: (☐) **Wearing seatbelt** (☐) **Not wearing seatbelt**

Patient's vehicle: (☐) **Auto** (☐) **Van** (☐) **Pick-up Truck** (☐) **Motorcycle** (☐) **Bicycle** (☐) **Other (Explain)**_____

Versus: (☐) **Auto** (☐) **Van** (☐) **Pick-up Truck** (☐) **Motorcycle** (☐) **Bicycle** (☐) **Other (Explain)**_____

Patient's vehicle was: (☐) **at a stop** (☐) **starting to move** (☐) **slowing down** (☐) **moving**

When it was struck… (☐) **FROM BEHIND** (☐) **right fender** (☐) **left fender**
(☐) **HEAD ON** (☐) **right fender** (☐) **left fender**
(☐) **SIDESWIPED** (☐) **right side** (☐) **left side**

Were the airbags deployed? (☐) **Yes** (☐) **No**

The Patient was: (☐) **unprepared** (☐) **had head turned to: right left rear** (☐) **was leaning on armrest etc.**

On impact, the patient: (☐) **braced for impact** (☐) **stepped hard on brakes** (☐) **forcibly held on to steering wheel**

Thereafter, patient was: (☐) **violently jolted back and forth** (☐) **jolted from side to side** (☐) **other** _____

Following the Impact:

The patient: (☐) **Denied loss of consciousness** (☐) **Lost consciousness…** (☐) **momentarily** (☐) **several minutes**

Thereafter felt: (☐) **Nervous** (☐) **Shocked** (☐) **Dazed** (☐) **Stunned** (☐) **Dizzy** (☐) **Confused**
(☐) **Disoriented** (☐) **Jittery** (☐) **Scared** (☐) **Panicky** (☐) **Lightheaded**
(☐) **Nauseated** (☐) **Other** _____

Patient experienced: (☐) **Vomiting** (☐) **Poor recollection of events** (☐) **Convulsions**

Patient sustained: (☐) **Head injuries** (☐) **Scalp bleeding / lacerations** (☐) **Cuts / Bruises on** _____

Patient noted pain: (☐) **Immediately following the accident** (☐) **Hours later** (☐) **The next morning**
(☐) **Over the next few days**

Pain was located in: (☐) **Neck** (☐) **Upper back** (☐) **Mid Back** (☐) **Lower Back** (☐) **Chest** (☐) **Abdomen** (☐) **Head**

(☐) **Shoulder…**	(☐) **right**	(☐) **left**	(☐) **Arm…**	(☐) **right**	(☐) **left**
(☐) **Elbow…**	(☐) **right**	(☐) **left**	(☐) **Wrist…**	(☐) **right**	(☐) **left**
(☐) **Hand…**	(☐) **right**	(☐) **left**	(☐) **Fingers…**	(☐) **right**	(☐) **left**
(☐) **Thigh…**	(☐) **right**	(☐) **left**	(☐) **Knee…**	(☐) **right**	(☐) **left**
(☐) **Leg…**	(☐) **right**	(☐) **left**	(☐) **Ankle…**	(☐) **right**	(☐) **left**
(☐) **Foot…**	(☐) **right**	(☐) **left**	(☐) **Toes…**	(☐) **right**	(☐) **left**

After the Accident:

Were paramedics at the scene (☐) Yes (☐) No Did they assist you at the scene (☐) Yes (☐) No

The patient went: (☐) Home (☐) Back to work/school (☐) To hospital via…(☐) paramedics (☐) self

Name of Hospital/Medical Center _____ Date admitted _____ released _____

Treatment rendered at hospital/center _____

List any other physicians seen as a result of THIS ACCIDENT:

_____

To date, what medication(s), physical therapy or chiropractic treatment has the patient undergone or received as a result of THIS ACCIDENT? _____

Is the patient still being treated? (☐) No (☐) Yes (Date of Last Treatment): _____)

Current Complaints

HEADACHES:

Frequency: (☐) Constant OR (☐) Intermittent
Intensity: (☐) Minimal (☐) Slight (☐) Moderate (☐) Severe
Nature: (☐) Dull (☐) Pounding (☐) Sharp (☐) Throbbing (☐) Pressure-type (☐) Shooting (☐) Splitting
Location: (☐) all over the head (☐) frontal area (☐) back (☐) right side (☐) left side

CURRENT COMPLAINTS (CONTINUED)

(☐) Chest pain	**(☐) Elbow pain (☐) R (☐) L**	**(☐) Ankle pain**	**(☐) R (☐) L**
(☐) Abdominal pain	**(☐) Forearm pain (☐) R (☐) L**	**(☐) Feet pain**	**(☐) R (☐) L**
(☐) Neck pain *front*	**(☐) Wrist pain (☐) R (☐) L**	**(☐) Knee pain**	**(☐) R (☐) L**
(☐) Neck pain *back*	**(☐) Hand pain (☐) R (☐) L**	**(☐) Thigh pain**	**(☐) R (☐) L**
(☐) Upper /mid back pain	**(☐) Shoulder pain (☐) R (☐) L**	**(☐) Hip pain**	**(☐) R (☐) L**
(☐) Lower back pain	**(☐) Upper arm pain (☐) R (☐) L**	**(☐) Lower leg pain**	**(☐) R (☐) L**

Any bruises, swelling, abrasions, lacerations? If so, explain in detail:_____

_____

_____

Mark any of the following associated complaints:

(☐) Blurred Vision (☐) Nausea/Vomiting (☐) Loss of Balance (☐) Dizziness (☐) Memory Loss (☐) Bowel Problem
(☐) Loss of Appetite (☐) Absent Mindedness (☐) Nervousness (☐) Confusion (☐) Ringing Nose in the Ears
(☐) Anxiety (☐) Insomnia (☐) Tension (☐) Restlessness (☐) Crying Spell (☐) Depression (☐) Bladder Problems

(☐) Limping due to pain in… (☐) right (☐) left extremity (☐) other _____

Describe any radiating pain; numbness or tingling sensations: _____

Describe any locking; snapping, crackling, popping or giving way: _____

_____

Activities that increase patient's symptoms:

(☐) Flexing/Bending (☐) Climbing (☐) Carrying (☐) Stooping (☐) Extending
(☐) Pushing (☐) Sitting (☐) Squatting (☐) Walking (☐) Twisting
(☐) Reaching Overhead (☐) Turning (☐) Standing (☐) Pulling (☐) Driving
(☐) Lifting (☐) Gripping (☐) Fine Manipulation (☐) Coughing (☐) Sneezing
(☐) Walking on Uneven Ground (☐) Changes in Weather, Temperature or Humidity (☐) Other _____

_____

How long can patient sit, stand or walk before changing position? _____

Describe patient's pre- injury capacity for lifting: _____

Have original symptoms (☐) Improved (☐) Remained the Same (☐) Worsened?

Using the following scale, circle the patient's average pain level:

No Pain		Minimal		Slight		Moderate			Severe	
0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

PAST MEDICAL HISTORY/PRIOR ACCIDENTS

Allergies: (☐) NO (☐) YES **To What?** _____

Abdominal Trauma	(☐) NO (☐) YES	IF YES, DID YOU FULLY RECOVER? ☐ NO	☐ YES
Chest Trauma	(☐) NO (☐) YES	IF YES, DID YOU FULLY RECOVER? ☐ NO	☐ YES
Fractures	(☐) NO (☐) YES	IF YES, DID YOU FULLY RECOVER? ☐ NO	☐ YES
Head Trauma	(☐) NO (☐) YES	IF YES, DID YOU FULLY RECOVER? ☐ NO	☐ YES
Other	(☐) NO (☐) YES	IF YES, DID YOU FULLY RECOVER? ☐ NO	☐ YES

Aids	(☐) NO	(☐) YES	**Treatment** _____
Arthritis	(☐) NO	(☐) YES	**Treatment** _____
Asthma	(☐) NO	(☐) YES	**Treatment** _____
Bronchitis	(☐) NO	(☐) YES	**Treatment** _____
Diabetes	(☐) NO	(☐) YES	**Treatment** _____
Heart disease	(☐) NO	(☐) YES	**Treatment** _____
Hepatitis	(☐) NO	(☐) YES	**Treatment** _____
High Blood Pressure	(☐) NO	(☐) YES	**Treatment** _____
Pneumonia	(☐) NO	(☐) YES	**Treatment** _____
Psychiatric Problems	(☐) NO	(☐) YES	**Treatment** _____
Tuberculosis	(☐) NO	(☐) YES	**Treatment** _____
Other	(☐) NO	(☐) YES	**Treatment** _____

↘ **explain** _____

Surgical History:

Appendectomy	(☐) NO	(☐) YES	**Date:** _____
Gallbladder	(☐) NO	(☐) YES	**Date:** _____
Herniotomy	(☐) NO	(☐) YES	**Date:** _____
Hysterectomy	(☐) NO	(☐) YES	**Date:** _____
Open Heart/Bypass	(☐) NO	(☐) YES	**Date:** _____
Tonsillectomy	(☐) NO	(☐) YES	**Date:** _____
Tubal Ligation	(☐) NO	(☐) YES	**Date:** _____
Other (specify)	(☐) NO	(☐) YES	**Date:** _____

↘ **explain** _____

Medications Currently Taking:

Name of Medication	Strength (mg/gm)	Daily Dosage	Length taking it

Previous Accidents/Injuries:

(☐) **Automobile** (☐) **Slip and Fall** (☐) **Work-related** (☐) **Other (Explain)** _____

Date & Description of prior accident (s): _____

SOCIAL HISTORY

Alcohol Intake: (☐) **Daily** (☐) **Weekly** (☐) **Occasionally** (☐) **Socially** (☐) **Seldom** (☐) **Never**

Tobacco Use: (☐) **Non Smoker** (☐) **Smoker** ____ **packs per…** (☐) **Day** (☐) **Week** (☐) **Month FOR** ____ **Years.**

FOR WOMEN ONLY: Pregnant? (☐) **NO** (☐) **YES (If Yes, How long?** _____ **) Date of Last Menstrual Period**