

PATIENT BASIC INFORMATION – AUTO ACCIDENT

DATE: _____

Name: _____ SS# _____
Address: _____ City _____ State _____ Zip _____
Date of Birth: _____
Gender: Male Female (*If female, are you pregnant at this time – Yes No – Initials* _____)
Marital Status: Single Married Divorced Widowed
Are you right handed or left handed? _____
Home phone number: (_____) _____ Work phone number: (_____) _____
E-mail address: _____
Place of employment: _____ Occupation: _____

Is there a **personal** history of:
Heart Trouble Stroke Cancer Diabetes Kidney Disease Thyroid Trouble Seizures Blood Pressure

Is there a **family** history of:
Heart Trouble Stroke Cancer Diabetes Kidney Disease Other _____
Father's Side
Mother's Side

•Have you lost time from work due to this accident? Yes No How much? _____

•Case type: (**circle one**) Auto accident Worker's Comp Slip & fall Other _____

•Describe your accident: _____

•Date of accident: _____ Time of accident: _____ AM PM

•What type of vehicle were you in? _____ What type of vehicle hit you? _____

•Your position in vehicle: (**circle one**) Driver Front Passenger Left rear passenger Right rear passenger
Other _____

•What was your vehicle doing at the time of the accident? (**circle one**) Stopped at light/stop sign Slowing down
Making a right turn Making a left turn Stopped in traffic Parking Proceeding along Other _____

•Visibility at time of accident: (**circle one**) Poor Fair Good

•Road conditions at time of accident: (**circle one**) Icy Wet Sandy Dark Clean & Dry

•Who hit who/what? (**circle one**) You hit other vehicle Other vehicle hit you You hit (**object**) _____

•Point of impact on your vehicle: (**circle one**) Head-on Left front Right front Rear-end
Left rear Right rear T-bone right side T-bone left side

•Damaged area of your vehicle: _____ What is the approximate amount of damage? \$ _____

•Amount of damage to your vehicle: (**circle one**) Mild Moderate Totaled

•Damaged area of other vehicle: _____ What is the approximate amount of damage? \$ _____

•Amount of damage to other vehicle: (**circle one**) Mild Moderate Totaled

•Did you see the accident coming? Yes____ No____

•Were you braced for the impact? Yes____ No____

•Did you have a seat belt on? Yes____ No____

•Does your vehicle have headrests? Yes____ No____

•Was headrest(**circle one**): Even with the top of your head Even with the bottom of your head Middle of neck

•What was the direction of your head at the time of the impact? (**circle one**)
Facing straight forward Turned to the right Turned to the left

Name: _____

Date: _____

DURING THE ACCIDENT:

•Did your body strike the inside of your vehicle? Yes ____ No ____
If yes, what part of body and area hit in car? _____

•Did you experience any of the following during or immediately following the injury?
____ Loss consciousness (if yes for how long)? _____
____ Dizziness ____ Dazed ____ Nausea ____ Vomiting

•Did the police show up at the scene? Yes ____ No ____

•Was an accident report filled out? Yes ____ No ____

•Where did you go after the accident? (**circle one**) Home Work Hospital ER Private Doctor
Name of hospital if you went there. _____

•How did you get there? (**circle one**) Drove self Somebody else Ambulance Police

•Where x-rays done? Yes ____ No ____ If yes what body parts were x-rayed? _____

•Was lab work done? Yes ____ No ____

•Were any medications prescribed? Yes No If so what kind? _____

•Please put a **Y** for yes or **N** for no to any items experienced **since this accident:**

- | | | |
|--------------------------|--------------------------|---------------------------------|
| ____ Pain while sleeping | ____ Nervousness/Anxious | ____ Shooting head pains |
| ____ Fainting | ____ Cold sweats | ____ Sinus trouble |
| ____ Loss of balance | ____ Intestinal gas | ____ Loss of smell |
| ____ Ringing in ears | ____ Constipation | ____ Neck stiffness |
| ____ Light bothers eyes | ____ Smoking | ____ Popping or grating in neck |
| ____ Loss of taste | ____ Chest pains | ____ Head feels heavy |
| ____ Fatigue | ____ Cold hands/feet | ____ Muscle spasms |

Please list any previous accidents with the dates and what type of injury you had:

•Circle any activities of your daily living which are difficult to perform **since this accident:**

- | | | | |
|---------------------------|--------------------------|--------------------------|-----------------------------------|
| Bathing | Putting on shoes | Sleeping | Lifting items from raised surface |
| Washing Hair | Making bed | Doing laundry | Lifting items from floor |
| Combing Hair | Eating | Taking out trash | Carrying small objects |
| Drying Hair | Preparing Meals | Going to toilet | Carrying large objects |
| Putting on clothes | Cleaning dishes | Concentrating | Climbing stairs |
| Standing for long periods | Sitting for long periods | Walking for long periods | Kneeling for long periods |

•If you are experiencing headaches, what part of your head hurts? ____ Front ____ Top and sides
____ Back of head

•How often during the day or night do you experience these headaches?

•Do your headaches prevent you from performing daily activities?

•What have you done to relieve your symptoms? _____

Name: _____

Date: _____

DESCRIBE YOUR CURRENT SYMPTOMS: Put **1** on the line in front of the **area** that hurts the **worst**, put **2** on the line in front of the area that is the **next worst**, **3** in the **third worst**, etc..

_____ **NECK** _____ Left side _____ Right side _____ Both sides

- Kind of pain in this area: (**circle all the ones that apply to your pain**):
Dull, sharp, aching, shooting, spasm, throbbing, burning, numbing, tingling
- Pain frequency in this area (**circle one**): Intermittent Occasional Frequent Constant
- Pain intensity in this area (**circle one**): Minimal Slight Moderate Marked

Circle all the movements that cause this pain to this area: Bending forward, Bending back, Bending left, Bending right, Twisting left, Twisting right, Coughing, Sneezing, Straining, Standing, Sitting, Lifting

_____ **UPPER BACK** _____ Left side _____ Right side _____ Both sides

- Kind of pain in this area: (**circle all the ones that apply to your pain**):
Dull, sharp, aching, shooting, spasm, throbbing, burning, numbing, tingling
- Pain frequency in this area (**circle one**): Intermittent Occasional Frequent Constant
- Pain intensity in this area (**circle one**): Minimal Slight Moderate Marked

Circle all the movements that cause this pain to this area: Bending forward, Bending back, Bending left, Bending right, Twisting left, Twisting right, Coughing, Sneezing, Straining, Standing, Sitting, Lifting

_____ **MID BACK** _____ Left side _____ Right side _____ Both sides

- Kind of pain in this area: (**circle all the ones that apply to your pain**):
Dull, sharp, aching, shooting, spasm, throbbing, burning, numbing, tingling
- Pain frequency in this area (**circle one**): Intermittent Occasional Frequent Constant
- Pain intensity in this area (**circle one**): Minimal Slight Moderate Marked

Circle all the movements that cause this pain to this area: Bending forward, Bending back, Bending left, Bending right, Twisting left, Twisting right, Coughing, Sneezing, Straining, Standing, Sitting, Lifting

_____ **LOW BACK** _____ Left side _____ Right side _____ Both sides

- Kind of pain in this area: (**circle all the ones that apply to your pain**):
Dull, sharp, aching, shooting, spasm, throbbing, burning, numbing, tingling
- Pain frequency in this area (**circle one**): Intermittent Occasional Frequent Constant
- Pain intensity in this area (**circle one**): Minimal Slight Moderate Marked

Circle all the movements that cause this pain to this area: Bending forward, Bending back, Bending left, Bending right, Twisting left, Twisting right, Coughing, Sneezing, Straining, Standing, Sitting, Lifting

_____ **OTHER** DESCRIBE: _____

- Kind of pain in this area: (**circle all the ones that apply to your pain**):
Dull, sharp, aching, shooting, spasm, throbbing, burning, numbing, tingling
- Pain frequency in this area (**circle one**): Intermittent Occasional Frequent Constant
- Pain intensity in this area (**circle one**): Minimal Slight Moderate Marked

Circle all the movements that cause this pain to this area: Bending forward, Bending back, Bending left, Bending right, Twisting left, Twisting right, Coughing, Sneezing, Straining, Standing, Sitting, Lifting

Name: _____ Date: _____

•Please write any additional information about the accident that was not covered:

FINANCIAL RESPONSIBILITY/AUTHORIZATION OF TREATMENT

Payment is expected at time of visit unless other arrangements are made in advance.

Name of person responsible for this payment: _____

Do you have health insurance? YES NO

Health Insurance Company's name: _____

You must provide this office with your health insurance card.

If any automobile insurance company will be charged – you must provide the following information:

Auto insurance Company name: _____ Phone#: _____

Adjuster in charge of case: _____ Claim #: _____

The insurance company must agree to honor direct payment to this office upon settlement of your case.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I also understand that I am responsible for payment for services rendered if my insurance company deems the provided services not medically necessary despite being clinically appropriate. Any amount authorized to be paid directly to the Island Chiropractic Centre will be credited to my account on receipt. 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 professional services rendered will be immediately due and payable. I also understand that if I am accepted as a patient by the physicians of Island Chiropractic Centre, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risks regarding chiropractic treatment will be explained to me upon my request. The doctor will not be responsible for any pre-existing medical conditions nor for any medical diagnosis. If health insurance is filed and paid, the full remaining amount of the bill is due regardless of the excepted amount paid by the insurance company.

Patient's Signature: _____ Date: _____

Guardian or Spouse's Signature Authorizing Care of a Minor: _____
Date: _____