NEW PATIENT INFORMATION

For Office use Only
Patient #

Patient's First Name_______________ Middle__________ Last________________ Date _____________
Address ___________________________________ City ____________________ Zip Code ___________
Home Phone _______________________________ Cell Phone_________________________________
E-mail ____ Social Security # _____________________
Employer Name ____
Job Title ____ Work Phone # _________________
Date of Birth ____________ Age____ Gender ___Male ___Female Handedness? R L
Weight____________ Height ___________ Marital Status S M W D
Spouse's Name__________________________________ Spouse's Date of Birth __________________
Whom may we thank for referring you to our office ____

At Fault Auto Insurance Company Name____________________________Claim #_______________
Adjustor's Name___________________________ Phone #___________________________________
Your Auto Insurance Company Name________________________ Claim # _____________________
Adjustor's Name___________________________ Phone #_________________________________
Name of Policy Holder _______________________
Uninsured/ Underinsured Motorist Coverage? □ Yes □ No______________________________
Personal Injury Protection (PIP)/Med Pay □ Yes □ No_________________________________
Amount of Coverage $ ____
Medical expenses to date as a result of the accident? $_____________________________________
Lost wages since accident $____
What is the repair amount of your car? $ ____
Do you have an attorney? □ Yes □ No

Lawyer/ Law Firm Name____________________________________**Phone #:**__________________

In case of emergency, whom should we contact ____

Phone #____

Do you have a primary care provider? □ Yes □ No

Name of Medical Doctor/Clinic Name _________________________ Phone Number _____________________

May we send updated status reports to your primary care provider? □ Yes □ No

Have you received any medical treatment since your accident? □ Yes □ No

Date you went to Hospital or any other provider? _________________________

Hospital Name:________________________ Were you taken in an ambulance? □ Y □ N

List any **X-Rays and CT Scans to which body parts**, **medications prescribed, braces, and any other procedures performed.**

____

____

Chiropractor__________________________ Procedures:____

Other____Cost________________________________

____

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____

Patient Signature _________________________________

ACCIDENT QUESTIONNAIRE

Today's Date____________ Date of Accident_____________

Please Describe the accident in your own words: ____

____

____

DESCRIBE YOUR VEHICLE

1. **Vehicle Type** :
   Make:__________________________________ Year:____________
   Model:___________________________
2. **Vehicle Size:**
   a. Compact
   b. Mid-Sized
   c. Full-Sized
   d. Truck
   e. Other_____________________

DESCRIBE THE ACCIDENT

3. **Actions of patient's vehicle: Circle all that apply**
   a. crossing an intersection
   b. stopped at an intersection
   c. stopped for a pedestrian
   d. stopped for traffic
   e. constant speed
   f. accelerating
   g. applying brakes
   h. turning

3b. Approximate speed of your vehicle_________mph

3c. Actions of other vehicle?
   a. Going straight
   b. Ran a stop sign or red light
   c. Turning
   d. Made an unsafe lane change
   e. Other________________________________
   ____

4. **How was the patient's vehicle hit:**
   a. hit head-on
   b. was hit on the driver's side
   c. was hit on the passenger side
   d. was rear-ended
   e. Other: _______________________________
5. **Damage to patient's vehicle:**
   a. complete
   b. extensive
   c. minimal
   d. moderate
6. **Describe the second vehicle:**
   a. compact
   b. full size
   c. mid size
   d. minivan or SUV
   e. pick-up truck
   Make:_________________________________ Year:____________
   Model:___________________________
7. **Damage to the other vehicle?**
   a. complete
   b. extensive
   c. minimal
   d. moderate

8. **Weather Conditions/Road Conditions**
   a. Clear b. Foggy
   c. Rainy/Wet d. Snow

9. Did your neck hit the headrest? Any other part of your body hit the car?
   a. Yes a. Yes
   b. No b. No
   If Yes please explain:____

9a. Any objects thrown around in the car? (glasses, cell phones, etc.)
Please List:____

DESCRIBE THE MOMENT OF IMPACT

9. **Body position at time of impact:**
   a. leaning forward e. slouched down in seat
   b. straight f. straight
   c. turned to the left f. turned to the right
10. **Head position at impact: 10a. Position of Hands on Steering Wheel**
   a. Straight a. both
   b. tilted forward b. left only
   c. turned to the left c. right only
   d. turned to the right
11. **Headrest position**
   a. even with the top of head
   b. even with the middle of head
   c. even with the bottom of head
12. **Type of restraint:**
   a. lap belt
   b. shoulder belt
   c. shoulder lap belt
13. **Place patient was seated in the vehicle:**
   a. Driver
   b. front passenger
   c. back passenger driver side
   d. back passenger right side
   e. back passenger middle
14. **Did Airbags deploy: 15a Did Seat Break**
   a. Yes a. Yes
   b. No b. No
15. **Aware prior to impact?**
   a. Yes
   b. No
16. **Onset of symptoms:**
   a. Immediate (within 1st 12 hours)
   b. Other_____________________
17. **Did you have any symptoms prior to the accident?**
   a. Yes
   b. No
   If yes please explain:_______________________________________
   ____

Patient Signature ____

SYMPTOMS

1. CIRCLE ALL YOUR COMPLIANTS

DO YOU HAVE LACERATIONS, CUTS OR BRUISING? :

c. Head or Face
d. Neck
e. Seat belt bruising
f. Cuts or bruising on your chest
g. Cuts or bruising on arms
h. Cuts or bruising on legs
i. Other: ___________________________

2. HEAD INJURIES: (now or at the time of the accident)

a. Were you knocked out or unconscious
b. Headaches
c. Face pain
d. Pupils different sizes
e. Dizziness
f. Difficulty walking
g. Balance problems
h. Room spins
i. Disoriented Confusion
j. Day dreaming
k. Attention problems
l. Hearing problems
m. Change in sense of smell or taste
n. Difficulty speaking
o. Memory problems
p. Very tired or fatigued
q. Appetite change
r. Sleep difficulties
s. Visual Disturbances, blurry or double vision
t. Flashbacks to accident
u. Problems to read or write
v. Problems adding or subtracting
w. Problems learning new things
x. Problems understanding
y. Problems remembering numbers
z. Difficulty Concentrating
aa. Difficulty remembering things
bb. Difficulty making decisions
cc. Change in Sexual Functioning
dd. Nausea / Vomiting
ee. Change of personality
ff. Wanting to be alone
gg. Mood swings
hh. Sadness
ii. Agitation
jj. Anger
kk. Helplessness
ll. Reduced confidence
mm. Apathy
nn. Irritability
oo. Sleepiness
pp. Frustration
qq. Impatience
rr. Other head related issues ___________________________

3. JAW PROBLEMS:

a. Jaw pain
b. Clicking
c. Pain while chewing
d. Pain while talking
e. Pain while yawning
f. Pain while moving jaw from side to side

4. NECK INJURIES:

a. Neck pain
b. Neck pain, numbness, tingling, weakness that radiates or goes down to RIGHT shoulder, arm, forearm or hand
c. Neck pain, numbness, tingling, weakness that radiates or goes down to LEFT shoulder, arm, forearm or hand
d. Neck pain, numbness, tingling, weakness that radiates or goes down to RIGHT UPPER BACK
e. Neck pain, numbness, tingling, weakness that radiates or goes down to LEFT UPPER BACK
f. Neck pain that causes headaches
g. Neck spasms or shoulder spasms
h. Popping, clicking or clunking sound with neck movement

e. Other ________________________________

5. SHOULDER INJURIES
a. Shoulder pain LEFT RIGHT BOTH
b. Shoulder pain with movement L R BOTH
c. Shoulder spasms LEFT RIGHT BOTH
d. Sharp shoulder pain
e. Dull shoulder pain
f. Achy shoulder pain
g. Pins and needles shoulder pain
h. Shoulder pain that radiates or shoots pain into arm
i. Other: ________________________________

6. UPPER ARM PAIN: RIGHT LEFT BOTH
a. Dull
b. Ache
c. Sharp
d. Stabbing
e. Other ________________________________

7. ELBOW PAIN: RIGHT LEFT BOTH
a. Dull
b. Ache
c. Sharp
d. Stabbing
e. Other ________________________________

8. FOREARM: RIGHT LEFT BOTH
a. Dull
b. Ache
c. Sharp
d. Stabbing
e. Other ________________________________

9. WRIST PAIN: RIGHT LEFT BOTH
a. Dull
b. Ache
c. Sharp
d. Stabbing

10. HAND PAIN: RIGHT LEFT BOTH
a. Dull
b. Ache
c. Sharp
d. Stabbing
e. Other ________________________________

11. MID BACK PAIN OR UPPER BACK PAIN
a. Upper or mid back pain
b. Upper back pain, numbness, tingling, weakness that radiates or goes down to RIGHT shoulder, arm, forearm or hand
c. Upper back pain, numbness, tingling, weakness that radiates or goes down to LEFT shoulder, arm, forearm or hand
d. Upper or mid back spasms

12. LOW BACK PAIN:
a. Low back pain
b. Low back pain, numbness, tingling, weakness that radiates or goes down to RIGHT buttock, thigh, leg or foot
c. Low back pain, numbness, tingling, weakness that radiates or goes down to LEFT buttock, thigh, leg or foot
d. Low back spasms

13. PELVIC OR SACRAL PAIN **Right Left** Both
a. Pelvic pain, numbness, tingling, weakness that radiates or goes down to RIGHT buttock, thigh, leg or foot
b. Pelvic pain, numbness, tingling, weakness that radiates or goes down to LEFT buttock, thigh, leg or foot
c. Sacral pain (tail bone)
d. Coccygeal or coccyx (tail bone) pain

14. HIP PAIN: RIGHT LEFT BOTH
a. Hip pain

b. Hip pain, numbness, tingling, weakness that radiates or goes down to buttock, thigh, leg or foot

15. UPPER LEG PAIN: RIGHT LEFT BOTH

a. Upper leg pain that radiates to knee

b. Upper leg spasms

16. KNEE PAIN: RIGHT LEFT BOTH

a. Knee pain that radiates to calf

b. Knee pain that radiates to calf and ankle

c. Knee pain that radiates to calf, ankle and foot

17. ANKLE PAIN: RIGHT LEFT BOTH

a. Ankle pain that radiates to foot

b. Ankle and foot pain

18. FOOT PAIN: RIGHT LEFT BOTH

19. CHEST PAIN

20. STOMACH PAIN

21. OTHER SYMPTOMS:

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Please place a checkmark by the condition that applies to you. Do the same for your family.

Family History Key: F = Father **M** = Mother **B** = Brother **S** = Sister **GF** = Grandfather **GM** = Grandmother

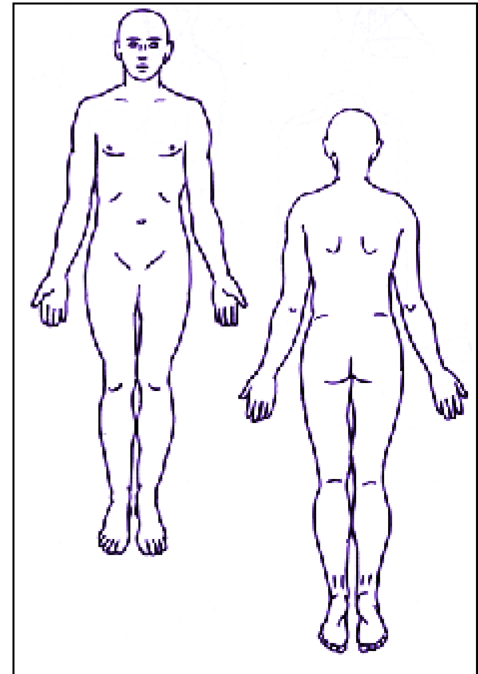
Family History

Y	N	Past Problem	When and Explanation of Condition (use back if needed)	F	M	B	S	GF	GM
		Cancer							
		Stroke							
		Thyroid Problems							
		Asthma							
		Heart Attack							
		HIV							
		Angina/Chest Pain							
		Diabetes							
		Arthritis							
		Other							

Patient Signature ____

Consultation Performed by_______________________________________

ON THE FIGURES AT RIGHT, PLEASE MARK YOUR AREA(S) OF PAIN OR DISCOMFORT.



Circle the areas (if more than one) of pain

Primary Symptom:____________________________________

How would you best describe the sensation of the pain/symptom:

Sharp Stabbing Aching Pins & Needles

Shooting Burning Dull Tingling/Numb

Intensity from 1-10 Please circle pain level

on average (1 2 3 4 5 6 7 8 9 10) at its worst (1 2 3 4 5 6 7 8 9 10)

The symptoms are: ( ) occasional ( ) intermittent ( ) frequent ( ) constant

What makes the symptoms better or worse?__________________________________

2nd Worst Symptom:____________________________________

How would you best describe the sensation of the pain/symptom:

Sharp Stabbing Aching Pins & Needles

Shooting Burning Dull Tingling/Numb

Intensity from 1-10 Please circle pain level

on average (1 2 3 4 5 6 7 8 9 10) at its worst (1 2 3 4 5 6 7 8 9 10)

The symptoms are: ( ) occasional ( ) intermittent ( ) frequent ( ) constant

What makes the symptoms better or worse?____

3rd Worst Symptom:_____________________________________

How would you best describe the sensation of the pain/symptom:

Sharp Stabbing Aching Pins & Needles

Shooting Burning Dull Tingling/Numb

Intensity from 1-10 Please circle pain level

on average (1 2 3 4 5 6 7 8 9 10) at its worst (1 2 3 4 5 6 7 8 9 10)

The symptoms are: ( ) occasional ( ) intermittent ( ) frequent ( ) constant

What makes the symptoms better and worse?____

Doctor Signature: ____

Patient Signature: ____

NAME:________________________________ **DATE:** ____/____/____ **Account#:** ______________________________

PLEASE LIST PAST SURGERIES:

1. ________________________________ Year______ 2. ________________________________ Year______
3. ________________________________ Year______ 4. ________________________________ Year______
5. ________________________________ Year______ 6. ________________________________ Year______

List any other key slips, falls or accidents you've had from childhood to present:	Date
1)	
2)	
3)	
4)	
5)	

Have you ever taken:	YES	NO	YEAR
Insulin			
Cortisone			
Thyroid Medicine			
Male/Female Hormones			
Blood Pressure			
Tranquilizers/Sedatives			
Birth Control			

What medications are you currently taking? (Include Date)	
1)	4)
2)	5)
3)	6)

Hospitalizations:

Marital Status: ____Married ____Divorced ____Single ____Separated ____Widowed

Number of Children:______ Children's Name(s): ________________________________

Frequency of Exercise: ____Never ____Rarely ____Occasionally ____Moderately ____Regularly

Intensity of Exercise: ____Low Level ____Medium Level ____High Level ____Competition Level

Sufficient Rest: ____Never ____Rarely ____Occasionally ____Moderately

Hours of Sleep: ____6 ____8 ____10 ____More than 10

Well balanced diet: ____Never ____Rarely ____Occasionally ____Moderately

Do you smoke? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 packs/day

Do you drink caffeinated beverages? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 drinks/day

Do you drink alcoholic beverages? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 drinks/day

Have you ever used street drugs? ____Yes ____No

Hobbies: ________________________________

____

Patient history was obtained from: _____Patient _____Father _____Mother _____Son _____Daughter

Notes / Comments: ________________________________

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Doctor Signature: ________________________________

Patient Signature: ________________________________