

Is there anything you do that makes your condition worse? _____

How has this condition affected your life? A) Home Life _____

B) Occupational Life _____

C) Recreational Life _____

D) Rest and Sleep Life _____

Have you ever been in an auto accident? ___past year ___past 5 years ___over 5 years ___never
ANY ACCIDENTS, FALLS, ETC. THAT MAY HAVE CAUSED YOUR PROBLEM _____

What surgery has been done? _____

FEMALE ONLY: Are you pregnant? ___Yes ___No

Drugs you now take: ___Nerve Pills ___Pain Killers ___Muscle Relaxers ___"Pep" Pills ___Tranquilizers
___Insulin ___Birth Control Pills ___Other (please list) _____

Any chiropractor consulted in the past? Name _____

Dates Consulted _____ For What Problem(s)? _____

Fees are payable at the time of x-rays, examinations, and treatments are received, unless other arrangements are made in advance. X-rays remain the property of this clinic (by law).

Patients Signature _____

Social Security # _____

Date _____

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING INFORMATION

Date of Accident _____ Time _____ am/pm Location _____

How did the accident occur? ___Auto Collision ___On-the-Job Injury ___Other _____

If not an auto collision, please describe the circumstances _____

Did you report the injury to your foreman or employer? ___Yes ___No

Did they recommend care at our office? ___Yes ___No

If an auto accident, were you ___Driver ___Passenger ___Pedestrian

If auto accident were you struck from ___Behind ___Right Side ___Left Side ___Front ___Auto was parked

Did your auto strike the other(s) involved ___Yes ___No Did the other auto strike yours? ___Yes ___No

As a result of the accident were citations issued to you? ___Yes ___No

Were citations issued to the driver of the other auto? ___Yes ___No

Were citations issued to the driver of your auto? ___Yes ___No

List the extent of your injuries as you know them: _____

Did you require post-accident hospitalization ___Yes ___No

PLEASE CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Diarrhea | |

Symptoms other than above: _____

Have you lost any days of work? ___Yes ___No Dates: _____

Name of Your Insurance Company involved _____

Name of Person Responsible Insurance Company _____

Have you been contacted by an Insurance Adjuster/Company Representative about this claim? ___Yes ___No

Do you have an attorney who has advised you in this case? ___Yes ___No Name _____

Address _____ Phone _____