Today's Date: _____ /_____/_____

WELCOME: The doctor and staff welcome you and want you to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will refer you to the appropriate healthcare provider. If you are a candidate for chiropractic care, then a treatment plan will be recommended to fit your individual needs.

INSTRUCTIONS: Please complete the following information in its entirety. The information submitted on this form is strictly confidential. If you have difficulty understanding any portion of this for, please ask the receptionist for assistance. If the question does not pertain to you, simply write in N/A for non-applicable.

PERSONAL INFORMATION

Name: (*First*)_____ (*Middle*)_____(*Last*)_____

Address: _____City: _____ State: _____ Zip: _____

Birth Date: _____ /_____/_____ Age:_____ Marital Status (*Circle*): Divorced Married Single Widowed

Gender (*Circle*): Male / Female

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Social Security #: _____-_____-_____ Email Address:_____@_____

Spouses Name: _____

Names & Ages of Children: _____

Is your spouse a patient in our office? □ Yes □ No _____

Employer /Employment Status □Employed □Unemployed □Full Time/□Part Time Student □Other

Business Name: _____ Occupation/Job Title: _____

Business Address: _____

Business Phone: (_____) _____-_____ Type of Work:_____

Is it ok to contact you at work? □ Yes □ No

Emergency Contact Information
Name: (*First*)_____ (*Middle*)_____(*Last*)_____

Address: _____ City: _____ State: ____ Zip: _____

Relationship: _____Home Phone: (___) ____-_____ Cell Phone: (___) ____-_____

Primary Care Physician: _____Physician Phone: (_____) _____-_____

AUTO ACCIDENT INSURANCE INFORMATION: If you have not completed an application of benefits from your auto carrier, you must do so for charges to be covered.

Auto Insurance Carrier:_____

Auto Insurance Carrier Phone #: _____ Ext. _____

Insurance Carrier Address: _____

Claim Adjuster's Name: _____ Claim Number: _____

GENERAL INSURANCE INFORMATION:

Who besides yourself is responsible for your bill? ☐Worker's Comp ☐Auto Insurance ☐Medicare

☐ Other (*Be Specific*): _____

Personal Health Insurance Carrier: _____

Health ID Card #: _____

Insured Person's Name: _____ Group #: _____

Insured Person's Date of Birth: _____ /_____/_____

Insured Person's Social Security #: _____-_____-_____

REVIEW OF SYSTEMS

INSTRUCTIONS: Below is a list of conditions that may seem unrelated to the purpose of your appointment. These conditions can affect your overall course of care. Please fill out all of the sections. If none of the conditions apply, select "None."

Constitutional:
☐**None**

☐Chills
☐Daytime Drowsiness
☐Fatigue
☐Fever
☐Night Sweats
☐Weight Gain
☐Weight Loss

Eyes/Vision:
☐**None**

☐Blindness
☐Blurred Vision
☐Cataracts
☐Change in Vision
☐Double Vision
☐Eye Pain
☐Field Cuts
☐Glaucoma
☐Photophobia
☐Tearing

Ears, Nose and Throat:
☐**None**

☐Bleeding
☐Dentures
☐Difficulty Swallowing
☐Discharge
☐Dizziness
☐Ear Drainage
☐Ear Infection*(s)*
☐Fainting
☐Headaches
☐ Prior Head Injury
☐Hearing Loss
☐Hoarseness
☐Loss of Smell
☐Nasal Congestion
☐Nose Bleeds
☐Sinus Infections
☐Sore Throats
☐Tinnitus
☐TMJ Disorder

Cardiovascular:
☐**None**

☐Chest Pain
☐Claudication
☐Heart Murmur
☐Heart Problems
☐Orthopnea
☐Palpitations
☐Shortness of Breath
☐Swelling of Leg*(s)*
☐Ulcers
☐Varicose Veins

Gastrointestinal:
☐**None**

☐Abdominal Pain
☐Belching
☐Constipation
☐Diarrhea
☐Difficulty Swallowing
☐Heartburn
☐Hemorrhoids
☐Indigestion
☐Jaundice
☐Nausea
☐Rectal Bleeding
☐Abnormal Stool
☐Vomiting
☐Vomiting Blood

Respiration:
☐**None**

☐Asthma
☐Coughing up blood
☐Shortness of Breath
☐Sputum Production
☐Wheezing
☐Strokes
☐Tremors

Allergy:
☐**None**

☐Food Intolerance
☐Itching
☐Nasal Congestion
☐Sneezing

Endocrine:
☐**None**

☐Cold Intolerance
☐Diabetes
☐Excessive Appetite
☐Excessive Hunger
☐Excessive Thirst
☐Frequent Urination
☐Goiter
☐Hair Loss
☐Heat Intolerance
☐Unusual Hair Growth
☐Voice Changes

Skin:
☐**None**

☐Changes in Nail Texture
☐Changes in Skin Color
☐Hair Growth
☐Hair Loss
☐Hives
☐Itching
☐ Numbness or Tingling
☐Rash
☐ Skin Disorders
☐Skin Lesions or Ulcers
☐Varicosities

Psychological:
☐**None**

☐Anxiety
☐Appetite Changes
☐Behavioral Change*(s)*
☐Bipolar Disorder
☐Confusion
☐Convulsions
☐Depression
☐Insomnia
☐Memory Loss
☐Mood Changes

Hematology:

☐**None**
☐Anemia
☐Bleeding
☐Blood Clotting
☐Blood Transfusion*(s)*
☐Bruises easily
☐Fatigue
☐Lymph Node Swelling

Female:
☐**None**

☐Birth Control Therapy
☐Breast Lumps / Pain
☐Burning Urination
☐Cramps
☐Frequent Urination
☐Hormone Therapy
☐Irregular Menstruation
☐Urine Retention
☐Vaginal Bleeding
☐Vaginal Discharge

Male:
☐**None**

☐Burning Urination
☐Erectile Dysfunction
☐Frequent Urination
☐Hesitancy or Dribbling
☐Prostate Problems
☐Urine Retention

Nervous System:
☐**None**

☐Dizziness
☐Facial Weakness
☐Headaches
☐Limb Weakness
☐Loss of Consciousness
☐Loss of Memory
☐Numbness
☐Seizures
☐Sleep Disturbance
☐Slurred Speech
☐Stress

AUTO ACCIDENT HISTORY

HISTORY OF OCCURRENCE Date of Accident _____/____/____

1. I was the/a: ☐Pedestrian ☐Driver ☐Passenger Left Front ☐Passenger Center Front

☐Passenger Right Front ☐Passenger Left Rear ☐Passenger Center Rear

☐Passenger Right Rear

a. What was your point of impact?

☐Head-On ☐Rear-End ☐Left Front ☐Left Rear ☐Right Front ☐Left Front

b. Did you feel pain immediately following the accident? ☐Yes ☐No

If you answered **NO**, how long after the accident was it before the pain started?

☐30min-1hr ☐1-4 hours ☐4 -12 hours ☐12 -24 hours ☐_____ Days

c. Where did you go after the accident? ☐Home ☐Work ☐Hospital ER ☐Private Doctor

d. Did you receive any of the following?:

☐x-ray ☐CT Scan ☐MRI ☐Lab work ☐Treatments/Medications

e. How did you get there? ☐Drove self ☐Somebody else ☐Ambulance ☐Police ☐Other: _____

f. List any doctors you've seen prior to this first visit to our office, their specialty, and any treatmentsreceived:_____

2. Patient Vehicle Type *(What type of car were you driving?)*

☐Compact ☐Mid-size ☐Full-size ☐SUV ☐Pick-up ☐Motorcycle ☐Other _____

3. Second Vehicle Type *(What was the opposing car type?)*

☐Compact ☐Mid-size ☐Full-size ☐SUV ☐Pick-up ☐Motorcycle ☐Other _____

4. Third Vehicle Type:

☐Compact ☐Mid-size ☐Full-size ☐SUV ☐Pick-up ☐Motorcycle ☐Other _____

5. Road Conditions: ☐Dry ☐Icy ☐Wet ☐Clear ☐Foggy ☐Dark ☐Other _____

6. Road Type: ☐Concrete ☐Asphalt ☐Gravel ☐Dirt ☐Other _____

7. Were you aware the accident was going to occur? ☐Yes ☐No

8. Were you wearing a seatbelt? ☐Yes ☐No

9. Did your airbag deploy? □Yes □No

10. Does your car have a headrest? □Yes □No

11. What position was the headrest in? □Up □Middle □Down

12. Head Position: *(At the time of the accident were you looking…)*

□Straight Ahead □Left Level □Left & Up □Left & Down □Right Level □Right & Up □Right & Down □Looking Up □ Looking Down.

13. Were you pushing the brake (stopping) either during or before impact? □Yes □No

14. Was your car moving before impact? □Yes □No

If yes, how fast? (mph) □<5 □6-10 □11-15 □16-20 □21-30 □31-40 □41-50 □51-60 □61-70 □>70

15. Was the driver of the second vehicle braking (stopping)? □Yes □No

16. Was the second vehicle moving before impact? □Yes □No

If yes, how fast? (mph) □<5 □6-10 □11-15 □16-20 □21-30 □31-40 □41-50 □51-60 □61-70 □>70

17. Was the driver of the third vehicle braking (stopping)? □Yes □No

18. Was the third vehicle moving before impact? □Yes □No

If yes, how fast? (mph.) □<5 □6-10 □11-15 □16-20 □21-30 □31-40 □41-50 □51-60 □61-70 □>70

COLLISION DETAILS *(Describe how the cars collided. My vehicle was…)*

19. First Impact: □Hit By Another Vehicle □Hit Another Vehicle □ Hit By An Object □Hit An Object

(My car was hit in the…) □Front □Front-Right □Front-Left □Left □Right □Right-Rear □Left-Rear □Rear □Top

20. Second Impact: □Hit By Another Vehicle □Hit Another Vehicle □Hit By An Object □Hit An Object

(My car was hit in the…)

□Front □Front-Right □Front-Left □Left □Right □Right-Rear □Left-Rear □Rea r □Top

COLLISION RESULTS *("During the accident my…")*

21. Body was thrown: □Backward □Forward □Left □Right □Can't Remember

22. Head Hit:

☐Airbag ☐Another Person's Body ☐Back Of Front Seat ☐Dashboard ☐Front Windshield

☐Rear-View Mirror ☐Side Window/Door ☐Steering Wheel ☐Windshield

23. Chest Hit:

☐Another Person's Body ☐Back Of Front Seat ☐Dashboard ☐Side Window/Door ☐Steering Wheel

24. Shoulders Hit:

☐Another Person's Body ☐Back Of Front Seat ☐Shoulder Harness ☐Side Window/Door

25. Knees Hit:

☐Another Person's Body ☐Back Of Front Seat ☐Center Console ☐Dashboard ☐Door Panel ☐Steering Wheel

26. Hips Hit:

☐Another Person's Body ☐Back Of Front Seat ☐Center Console ☐Dashboard ☐Door Panel ☐Steering Wheel

If other area then describe:_____

VEHICLE DAMAGE

27. First Vehicle (*your car*): ☐Totaled ☐Significant Damage ☐Light Damage ☐No damage

28. Second Vehicle (*opposing car*): ☐Totaled ☐Significant Damage ☐Light Damage ☐No damage

29. Third Vehicle: ☐Totaled ☐Significant Damage ☐Light Damage ☐No damage

PERSONAL INJURY

30. Were you hospitalized? ☐Yes ☐No ***(If yes, please answer the questions in the paragraph below.)***

If yes, when were you hospitalized? Date ____/_____/_____

☐How were you transported to the hospital? ☐Ambulance ☐Life Flight ☐Private Transportation

☐What did the hospital recommend? ☐No Instructions ☐See This Clinic ☐See DC

☐See Own Doctor ☐See Neurologist ☐See Orthopedist ☐Over The Counter Medication ☐Prescription Medication ☐Other: _____

Did you have any x-rays, CT Scans or MRI's taken? ☐Yes ☐No

If yes, what areas? _____

31. Describe all of your symptoms/complaints/conditions here: (i.e. Low Back Pain, Neck Pain, Right Shoulder Pain)

_____

_____

_____.

32. Describe the quality of your symptoms: □Burning Pain □Diffuse □Dull/Aching □Localized

□Radiating □Sharp □Shooting □Stabbing □Throbbing □Tightness □Tingling □Other _____

33. How would you describe your current symptoms: □Pain □Numbness □Stiffness □Weakness

34. On a scale of 0 to 10**, zero being the lowest level and ten being the highest**, how would you rate the effect your condition or pain has **on your daily functioning when you are at rest**? Please circle.

0 1 2 3 4 5 6 7 8 9 10

35. On the same scale of 0 to 10, **zero being the lowest level and ten being the highest**, how would you rate the effect your condition or pain has **on your daily functioning when you are active**?

0 1 2 3 4 5 6 7 8 9 10

36. Did this condition originally begin before the accident? □ Yes □ No

If yes, when? _____

37. Is your condition currently… □Worsening □Improving □ Unchanged?

38. If you condition has worsened or is worsening, when did the increased symptoms start? _____.

39. When was the last time you experienced these symptoms?_____.

40. a) Is your condition is worse in the: □Morning □Afternoon □Night □With Activity

b.) and is it mostly:

□ Occassionally throughout the day (0-25%) □ Frequently throughout the day (26-50%)

□Intermittent throughout the day (51-75%) □Constant throughout the day (76-100%)

41. Is your condition better in: □Warm Temp □Cold Temp □Neither

42. Is your condition worse in: □Warm Temp □Cold Temp □Damp □None

43. Check any of the following signs or symptoms that are associated with your current condition:

☐Headaches (Describe your headaches in detail):_____
☐Blurred Vision ☐Depression ☐Dizziness ☐Irritability / Mood Swing ☐Ringing in the ears ☐Fainting
☐Confusion ☐Loss of Concentration ☐Loss of Smell ☐Localized Tingling ☐Nausea ☐Ringing in Ears
☐Stiffness ☐Problems Sleeping ☐Aches ☐Cold Limb ☐Dizziness ☐Ecchymosis ☐Fatigue ☐Fever
☐Heartburn ☐Muscle Spasm ☐Nausea ☐Numbness ☐Pale Bluish Skin ☐Panic ☐Pins & Needles
☐Runny Nose ☐Short Breath ☐Stiffness ☐Sweating ☐Swelling ☐Tingling ☐Vomiting
☐Radiating Pain/Sensation (Describe the location and type of sensation): _____
☐Weakness (Describe the location): _____
☐Other not Listed Describe):_____

44. Do your symptoms seem to be better with:

☐Nothing ☐Activity ☐Bending ☐Cold ☐Heat ☐Massage ☐Movement ☐Over-The-Counter Medications
☐Prescription Medications ☐Rest ☐Stretching ☐Sitting ☐Standing ☐Twisting ☐Walking
☐ Other:_____

PAST HEALTH HISTORY

This section will identify key factors and indicators about your history that may impact or contribute to your current health condition. Please give us information on any below that apply to you.

45. Please list any medications or nutritional supplements that you are currently taking:

_____
_____.

46. Please list any other doctors or providers that you have seen for this condition or for any conditions that you may be currently treating and the type of treatments provided:

_____
_____.

47. Childhood Illnesses (Please list any illnesses that you have had as a child):

_____
_____.

48. Adult Illnesses (Please list any illnesses that you have had as an adult):

_____
_____.

49. Surgeries (Please list all surgical procedures that have had in the past):

_____.

50. Injuries (Please list any significant injuries, falls, trauma, accidents that you have had in the past):

_____
_____.

51. Immunizations (Please list any vaccinations that you have had):

_____.

52. Non Drug Allergies and how you react to those substances (i.e. mold, hay fever, etc):

_____

_____.

FAMILY HISTORY

This section will identify any possible genetic characteristics or risk factors that may impact or contribute to your current health condition.

53. Please describe your family history: ***If you do not know, please do not leave blank, mark N/A***

General Family: Alive Deceased Health Conditions / Diseases / Conditions

Father: _____

Mother: _____

Paternal Grandfather _____

Paternal Grandmother _____

Maternal Grandfather _____

Maternal Grandmother _____

Son(s): _____

Daughter(s): _____

Brother(s): _____

Sister(s): _____

SOCIAL & WORK HISTORY

This section will identify key factors and indicators about your lifestyle that may impact or contribute to your current health condition. Please check as many as apply.

54. Please describe you alcohol use: ☐Social Consumption Only ☐Beer ☐Liquor ☐Wine

How much alcohol do you regularly drink? _____.

55. Please describe your average diet: _____.

56. What is the highest education level you have attained? _____.

57. Have you ever used illegal substances or IV drugs? ☐Yes ☐No

58. Please describe your tobacco use:

☐None ☐I live with a smoker ☐I smoked/chewed but quit ☐I currently smoke ☐I currently chew

59. Please describe your condition's effect on your activities of daily living (ADL's):

- Caring for Family: ☐No Effect ☐Painful (I can do it) ☐Painful (I'm limited) ☐Unable to Perform
- Carrying Groceries: ☐No Effect ☐Painful (I can do it) ☐Painful (I'm limited) ☐Unable to Perform
- Change Position (Sit to Stand): ☐No Effect ☐Painful (I can do it) ☐Painful (I'm limited) ☐Unable to Perform
- Climbing Stairs: ☐No Effect ☐Painful (I can do it) ☐Painful (I'm limited) ☐Unable to Perform
- Daily Pet Care: ☐No Effect ☐Painful (I can do it) ☐Painful (I'm limited) ☐Unable to Perform
- Driving: ☐No Effect ☐Painful (I can do it) ☐Painful (I'm limited) ☐Unable to Perform
- Extended Computer Use: ☐No Effect ☐Painful (I can do it) ☐Painful (I'm limited) ☐Unable to Perform
- Household Chores: ☐No Effect ☐Painful (I can do it) ☐Painful (I'm limited) ☐Unable to Perform
- Lifting Children: ☐No Effect ☐Painful (I can do it) ☐Painful (I'm limited) ☐Unable to Perform
- Self Care–Bathing: ☐No Effect ☐Painful (I can do it) ☐Painful (I'm limited) ☐Unable to Perform
- Self Care–Dressing: ☐No Effect ☐Painful (I can do it) ☐Painful (I'm limited) ☐Unable to Perform
- Self Care–Shaving: ☐No Effect ☐Painful (I can do it) ☐Painful (I'm limited) ☐Unable to Perform
- Sexual Activities: ☐No Effect ☐Painful (I can do it) ☐Painful (I'm limited) ☐Unable to Perform
- Sleeping: ☐No Effect ☐Painful (I can do it) ☐Painful (I'm limited) ☐Unable to Perform
- Static Sitting: ☐No Effect ☐Painful (I can do it) ☐Painful (I'm limited) ☐Unable to Perform
- Static Standing: ☐No Effect ☐Painful (I can do it) ☐Painful (I'm limited) ☐Unable to Perform
- Walking: ☐No Effect ☐Painful (I can do it) ☐Painful (I'm limited) ☐Unable to Perform
- Yard Work: ☐No Effect ☐Painful (I can do it) ☐Painful (I'm limited) ☐Unable to Perform

60. Please list any recreational activities or hobbies and describe your condition's effect on those activities:

List: _____ ☐No Effect ☐Painful (I can do it) ☐Painful (I'm limited) ☐Unable to Perform

List: _____ ☐No Effect ☐Painful (I can do it) ☐Painful (I'm limited) ☐Unable to Perform

List: _____ ☐No Effect ☐Painful (I can do it) ☐Painful (I'm limited) ☐Unable to Perform

List: _____ ☐No Effect ☐Painful (I can do it) ☐Painful (I'm limited) ☐Unable to Perform

61. Please describe you current employment status:

☐Student (Part / Full Time) ☐Unemployed ☐Retired☐Homemaker ☐Not Working (LOA) ☐Not Working (Summer Break) ☐Partially Disabled (%___) ☐100% Disabled ☐Disabled Veteran (%___) ☐100% Disabled Veteran ☐Currently Employed as a:_____.

62. How would you classify your job based on the following lifting limits?

☐Sedentary (Less than 5 lbs.) ☐Light (6 to 20 lbs.) ☐Moderate (21 to 49 lbs.) ☐Heavy (Greater than 50 lbs.)

63. How often do you lift at your job?

☐Constant (66 to 100% of the day) ☐Frequent (33 to 65% of the day) ☐Occasional (0 to 32% of the day)

64. Lifting Postures:

☐Sitting ☐Kneeling/Stooping ☐Arms Up ☐Shoulder ☐Standing ☐Abnormal Position ☐Abnormal Position

65. How many hours per day do you do each of the following activities?

☐Sitting: _____ ☐Standing: _____ ☐Walking: _____ ☐Climbing: _____ ☐Pushing: _____

☐Pulling: _____ ☐Kneeling: _____ ☐Reaching: _____ ☐Twisting: _____

66. If you lift at work, what type of lifting is most frequent?

☐Torso Level ☐Knee Level ☐Floor Level ☐Arm Level ☐Shoulder Level ☐High and Near ☐Off Posture / Off Balance ☐Standing & Twisting ☐Standing, Twisting & Bending ☐Sitting & Twisting ☐Sitting, Twisting & Bending ☐Other (Explain):_____.

67. Please describe your condition's effect on your job performance:

☐No Effect ☐Painful (I can do it) ☐Painful (Limited Ability) ☐Painful (Limited Duty)

☐Unable to Perform (No Limited Duty) ☐Unable to Perform (Can Not Do Limited Duty)

Is there any other information that you feel would be relevant to your current condition that was not covered? Please explain in the following section any information that you feel would be helpful to the doctor in reviewing your case.

_____
_____
_____
_____
_____
_____.