

New Patient Information

Date ____/____/____

Patient number _____

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work phone _____

Cell Phone _____ Email Address _____

Would you like to receive text or email appointment reminders? Y/N Cell carrier _____

Occupation _____ Would you like access to online scheduling? _____

Emergency Contact: _____ Phone _____

Marital Status (circle one): Single/Married/Divorced/Widowed/Legally Separated

Spouse's Name _____

How did you hear about us?

Referred by: Patient Name _____ Physician Name _____

Yellow Pages/Insurance Company/Other _____

Consent of Treatment of a Minor:

I hereby authorize First Choice Chiropractic and whomever he/she may designate to assist and administer chiropractic and physical care as he/she deems necessary to my son/daughter.

Parent Signature _____ Date _____

Females Only

I, _____, to the best of my knowledge confirm that I am not pregnant and waive all responsibility to the Doctor.

Signature _____ Date _____

Accident History Questionnaire

PERSONAL INJURY PATIENT HISTORY

Name _____ Date _____

1. Date of Accident: _____ 2. Time: _____ AM/PM
3. Driver of Car: _____
4. Where were you seated? _____
5. Who owns the car? _____
6. Year & Model of your car. _____
Year & Model of the other car. _____
7. What was the approximate damage done to your car? \$ _____
8. Visibility at time of accident: poor fair good other: _____
9. Road conditions at time of accident: icy rainy wet clear dark
 other (describe): _____
10. Where was your car struck?

FRONT



REAR

In your own words, please describe accident: _____

11. Type of Accident: Head-on collision Broad-side collision Front Impact
 Rear-end car in front Rear impact Non-collision
12. At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car: _____
13. Did you see the accident coming? yes no
14. Did you brace for impact? yes no
15. Were seatbelts worn? yes no
16. Were shoulder harnesses worn? yes no
17. Does your car have headrests? yes no
18. If yes, what was the position of those headrests compared to your head before the accident? Top of headrest even with **bottom** of head
 Top of headrest even with **top** of head
 Top of headrest even with **middle** of neck
19. Was your car braking? yes no
20. Was your car moving at the time of the accident? yes no
21. If yes, how fast would you estimate you were going? _____ mph
22. How fast would you estimate the other car was going? _____ mph
23. Head/Body position at the time of impact:
 Head turned left/right Body straight in sitting position
 Head looking back Body rotated right/left
 Head straight forward Other: _____
24. As a result of the accident you were: Rendered unconscious In shock
 Dazed, circumstances vague Other: _____
25. How was the shoulder harness adjusted? Loose Snug
26. Were you wearing a hat or glasses? yes no
27. Could you move all parts of your body? yes no

28. If no, what parts couldn't you move and why? _____

29. Were you able to get out of the car and walk unaided? Yes No

30. If no, why not? _____

31. Did you get any bleeding cuts? Yes No If yes, where? _____

32. Did you get any bruises? Yes No If yes, where? _____

33. Please describe how you felt:

Immediately after the accident: _____

Later that day: _____

The next day: _____

34. Check symptoms apparent since the accident:

- | | | |
|---|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Neck pain/Stiffness | <input type="checkbox"/> Mid back pain |
| <input type="checkbox"/> Eyes Light Sensitive | <input type="checkbox"/> Pain Behind Eyes | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Numbness in fingers |
| <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Loss of taste |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Breath shortness |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Depression | <input type="checkbox"/> Ringing/Buzzing |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Tension | <input type="checkbox"/> Cold hands |
| <input type="checkbox"/> Cold feet | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Clicking or Popping Jaw |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Other _____ | |

35. Occupation: _____

36. Employer: _____

37. Have you missed time from work: yes no

38. If yes, full time off work: _____ to _____

39. If yes, part time off work: _____ to _____

40. Did you seek medical help immediately after the accident? yes no

41. If yes, how did you get there? Ambulance Police

Someone else drove me Drove own car Other: _____

42. Doctor #1: Name: _____

43. First Visit Date: _____

44. Were you examined? yes no

45. Were X-rays taken? yes no

46. Did you receive treatment? yes no Medications Braces Collars

47. If yes, what kind of treatment did you receive? _____

48. What benefits did you receive from the treatment? _____

49. Date of last treatment: _____

50. Doctor #2: Name: _____

51. First Visit Date: _____

52. Were you examined? yes no

53. Were X-rays taken? yes no

54. Did you receive treatment? yes no

55. If yes, what kind of treatment did you receive? _____

56. What benefits did you receive from the treatment? _____

57. Date of last treatment: _____

58. Do you have an attorney on this claim? yes no

59. If yes, who? _____

Address _____

City _____ State _____ Zip _____ Phone _____

Illustrate below how the accident happened

Past Medical History: Place an (X) if it applies and describe.

None related to current complaints Hospital or operation

Auto Accident Work Accident Illness Other

Describe _____

Family History: Place an (X) if any family member has suffered from:

Tuberculosis Kidney Disease Spinal Disorder

Mental Illness Epilepsy Diabetes

Gout Allergy Arthritis

Hypertension Cancer Migraines

Heart Attack Other, list: _____

Personal History: Place an (X) if it applies, describe.

Single Married Divorced Separated Widow/Widower

Number of Children _____ Number of Children at home _____

Employed Spouse yes no

Are you pregnant? yes no not sure

Medications, describe _____

Disease, describe _____

Other, describe _____

SYSTEM REVIEW Place an (X) next to the symptoms you know you have

Genito-Urinary System

- Bladder trouble
- Painful urination
- Excessive urination
- Discolored urine
- Scanty urination

Gastro-Intestinal System

- Poor appetite
- Difficult swallowing
- Vomiting food
- Constipation
- Hemorrhoids
- Weight trouble
- Excessive hunger
- Excessive thirst
- Abdominal pain
- Black stool
- Liver trouble
- Difficult chewing
- Nausea
- Diarrhea
- Bloody stool
- Gall bladder trouble

Nervous System

- Numbness
- Dizziness
- Muscle jerking
- Confusion
- Loss of feeling
- Fainting
- Convulsions
- Depression
- Paralysis
- Headaches
- Forgetfulness

Cardio-Vascular System

- Chest pain
- Persistent Cough
- Rapid heartbeat
- Lung problems
- Pain over heart
- Coughing phlegm
- High blood pressure
- Varicose veins
- Difficult breathing
- Coughing blood
- Heart problems
- Other

Eye, Ear, Nose and Throat System

- Eye strain
- Ear pain
- Hearing loss
- Nose discharge
- Sore mouth
- Speech difficulty
- Eye inflammation
- Ear noises
- Nose pain
- Breathing difficulty
- Sore throat
- Dental problems
- Vision problems
- Ear discharge
- Nose bleeding
- Sore gums
- Hoarseness

PRIMARY COMPLAINT:

When did this condition develop? _____ Did it develop? (Circle one) Immediately/Gradually?

What is the exact location of your symptoms? _____

What do you think caused this condition? _____

How often do you experience these symptoms? (Circle one)
Constant / Frequent (75%) / Often (50%) / Seldom (25%) / Rarely (less than 25%)

What is the type of pain you are experiencing? (Circle all that apply)
Dull Sharp Burning Aching Stabbing Throbbing Numbness Twitching

Rate your symptoms on a scale of 1-10 (circle one) minimal 1 2 3 4 5 6 7 8 9 10 severe

Does the pain travel or radiate to another area of your body? YES ___ NO ___
If yes, what area? _____

What provokes or aggravates your condition (circle all that apply)?
Sitting / Standing / Walking / Lying / Pushing / Pulling / Lifting / Hot / Cold / Sneezing / Bowel Movements

What helps alleviate pain (circle all that apply)?
Sitting / Standing / Walking / Lying / Rest / Hot / Cold

Please list any doctors that you have seen for this condition (Include address, phone numbers, fax numbers, diagnosis, treatment received, and any change in your condition since you have received Treatment): _____

List any falls, surgeries, hospitalizations, or accidents since your last visit: _____

Patient name: _____

SECONDARY COMPLAINT: (If Applicable)

When did this condition develop? _____ Did it develop? (Circle one) Immediately/Gradually?

What is the exact location of your symptoms? _____

What do you think caused this condition? _____

How often do you experience these symptoms? (Circle one)

Constant / Frequent (75%) / Often (50%) / Seldom (25%) / Rarely (less than 25%)

What is the type of pain you are experiencing? (Circle all that apply)

Dull Sharp Burning Aching Stabbing Throbbing Numbness Twitching

Rate your symptoms on a scale of 1-10 (circle one) minimal 1 2 3 4 5 6 7 8 9 10 severe

Does the pain travel or radiate to another area of your body? YES ___ NO ___

If yes, what area? _____

What provokes or aggravates your condition (circle all that apply)?

Sitting / Standing / Walking / Lying / Pushing / Pulling / Lifting / Hot / Cold / Sneezing / Bowel Movements

What helps alleviate pain (circle all that apply)?

Sitting / Standing / Walking / Lying / Rest / Hot / Cold

Please list any doctors that you have seen for this condition (Include address, phone numbers, fax numbers, diagnosis, treatment received, and any change in your condition since you have received Treatment): _____

Additional Notes: