PERSONAL HISTORY

#____________________ Date________________

Please complete this form to the best of your ability. If you need help our receptionist will be glad to assist you!

Full Name ______________________ Address ______________________

City ______________________ State ______________ Zip ______________

Phone (Home)______________ Phone (Work) ______________ Cell ______________

E-mail ______________________ Sex: M F Single / Separated / Married / Widowed / Divorced

Please note that we respect your privacy, and will not loan, sell, or otherwise distribute your e-mail information to any third party.

Birth ____________Social Security# ______________Do you like appointment reminder calls? No/ Cell/ Home

How did you hear about our office? TV Phonebook Newspaper Billboard Website Family/Friend ______________

Employed / Student / Other Emergency Contact ______________________Phone____________

Spouse's Name______________ Date Of Birth ____________Social Security# ______________

Employer ____

Accident Injury and Insurance Information

Could your present problems be due to an accident-injury?______________Date ______________

Type of accident-injury (circle): **Auto, On-the-Job, Slip/Fall, Personal, Other** ______________

Name of Attorney handling your case______________________Phone ______________

Type of Insurance you plan to use to help pay your account (circle): **Auto Health Medicare Work Comp Self-Pay Other**

Insurance company ______________________Phone ______________

Insured's Name______________________ Insured's DOB ______________

Your Injury, Illness, or Condition

What is your injury, illness or condition ______________________________

Previous interventions, treatments, medications, surgery, or care you've sought for your injuries ______________

____

Do you suffer from any condition other than that which you are now consulting us?______________________

Have you had previous Chiropractic care? YES NO Condition treated____________ Month/Year of last visit________

Have you previously had Physical Therapy? YES NO Condition treated____________ Month/Year of last visit________

Prior Surgeries

Date ____________ Type______________________________

Date ____________ Type______________________________

Date ____________ Type______________________________

 Patient: ____________________________ Patient# _____________ Doctor:_____________

Health History / Trauma

CIRCLE conditions you have NOW and UNDERLINE conditions you have had PREVIOUSLY:

Low Back Pain	Fractured Bones	Spinal Taps	Fainting
Arm Pain	Dislocation	Scoliosis	Birth Defects
Headaches	Joint Replacement	Diabetes	Osteoporosis
Neck Pain	Metal Screws/implants	High Blood Pressure	Cancer
Pain Between Shoulders	Cervical Whiplash	Stroke	Tumor
Leg Pain	Electronic Implant	Aneurysm	Cyst
Cold/Tingling Fingers or Toes	Pacemaker	Convulsions	Ear Infections
Numbness	Ruptured Spinal Disc	Seizures	Birth Complications
Allergies	Slipped spinal disc	Memory Lapse	Asthma
Loss of Sleep	Pinched Nerve	Dizziness	Bed Wetting
Stomach/Digestive Problems	Spinal Surgery	Concussion	Heart Disease
Walking problems	Spinal Infections	Knocked Unconscious	Fever

Are you Pregnant? Y_____N_____ Other serious illness____

Previous injuries or trauma not listed above ____

____

Current Medications

Name ______________________________ Reason for taking______________________________________

Name ______________________________ Reason for taking______________________________________

Name ______________________________ Reason for taking______________________________________

Social and Occupational History ____

Job description ____

Recreational Activities ____

Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet) ______________________________

____

Family Health History

Associated health problems of relatives ____

____

Treatment Authorization

Today you'll receive a free initial consultation with the doctor. If further tests are needed such as exams or x-rays, the necessity and cost will be explained before they are performed. You'll be happy to know that these tests are covered by most insurances. I hereby authorize this office and its staff and doctors to examine and treat my condition as the doctors deem appropriate. I grant authority for these procedures to be performed. I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment of services by this office. Should collection of past due amount become necessary, I will become responsible for all charges, fees and attorney fees. I (we) hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient's signature (x) ______________________________________ Date

Entered by__________________

Patient: ____________________________ Patient# _____________ Doctor:_____________

Auto Accident Mechanism of Injury Form

If your injuries could be due to an AUTO ACCIDENT, please fill out this page .

Please fill in the blanks or circle the appropriate response(s)

Date of Accident ______________________ Accident State (AL?)__________ Hour of incident _______________AM / PM

Please describe how the collision happened ____

What was your position in the car? **Driver** / **Front Passenger** / **Left Rear** / **Right Rear**

If "Driver" were your hands on the steering wheel? **Both** / **Left** / **Right** Did the airbags deploy? **Yes** / **No**

Did you strike another vehicle? **Yes** / **No** Did another vehicle strike your vehicle? **Yes** / **No**

Angle of Impact: **Front** / **Back** / **Left** / **Right** / **Other**:__________________________________

If Second Collision – Angle of 2nd impact: **Front** / **Back** / **Left** / **Right** / **Other**: __________________________

In relation to the back of your head, was your headrest set: **Low** / **Middle** / **High**

Were you surprised by the impact? **Yes** / **No** If "NO", how did you brace? **With Hands** / **With Feet**

Where was your head facing at the time of impact? **Straight Ahead** / **Left** / **Right** / **Behind**

Were you leaning forward at the time of impact? **Yes** / **No**

What type and year of vehicle were you in?____

What was the approximate speed of your vehicle when the accident occurred? _________ mph. Speed of other vehicle ________ mph

What type and year of vehicle struck yours?____

Were you wearing a seatbelt? **Yes** / **No** What type: **Lap Belt** / **Shoulder Belt** / **Both**

Did you feel pain immediately after the accident? **Yes** / **No** Were you rendered unconscious? **Yes / No**

Did you strike anything in the vehicle at the time of impact? **Yes** / **No** If "YES", specify what part of your body struck what: (i.e. head, chest, chin, shoulder, knee, etc.)

- □ Steering Wheel
- □ Dashboard
- □ Left Side Door
- □ Left Window
- □ Other____
- □ Windshield
- □ Roof
- □ Right Side Door
- □ Right Window

Did your seat break or bend? **Yes** / **No**

Immediately following the accident, how did you feel? (Circle all that apply) **Dizzy** / **Dazed** / **Weak** / **Upset** / **Disoriented** / **Nervous** / **Nauseous** / **Other**: ______________________________________

Police and Ambulance

Was the accident reported to the police? **Yes** / **No**

Were traffic citations issued? **Yes** / **No** If "YES", to whom? ______________________________

Did you go to the hospital? **Yes** / **No** If "YES", when? ______________________________

If "YES", how did you get there? **Ambulance** / **Police Car** / **Private Transportation**

Were you admitted? **Yes** / **No** If "YES", how long? ______________________________

Name of Hospital? ______________________________ Attended by Dr.________________________

What treatment given? (Circle all that apply) **None** / **X-rays** / **Pain Medication** / **Stitches / Muscle Relaxants** / **Bandaged** /

Cervical Collar / **Physical Therapy** / **Instructed Regarding Concussion** / **Instructed Regarding Sprains & Strains** /

Instructed to Call an Orthopedist / **Instructed to Call a Private Physician** / **Referred to This Office** /

Other: ____

What other doctor have you seen as a result of this injury?______________________________

Do you have difficulty in excessive: **Standing** / **Walking** / **Riding** / **Bending** / **Twisting**

Do you have difficulty in excessive lifting: **Light** / **Moderate** / **Heavy** / **Repetitive**

Symptoms other than above: ____