Chiro 1 Express

CONFIDENTIAL PATIENT INFORMATION

AUTO ACCIDENT HISTORY FORM

PERSONAL INJURY HISTORY INFORMATION:

Name: ____ Date: _______________

Date of Birth________/_________/________ Social Security Number:____________________________

Age:_______ Gender: ❑ M ❑ F Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Home Address:____

City:______________________________ State:______________ Zip Code:__________________

Home Phone:_______________________ Work:___________________ Cell:_________________

May We Contact You At Work?: ❑ Yes ❑ No

Employer:____

Your Occupation/Title:____

LIABILITY INFORMATION:

Has the accident been reported to the liability insurance company? ❑ Yes ❑ No

Have you been contacted by any insurance company? ❑ Yes ❑ No

Insurance Carrier:________________________________ Phone:______________________

Name of Insured:_________________________________ Claim #:____________________________

Name of Adjuster:_______________________________

Address to mail claim(s):____ City:________________

State:_________ Zip:__________ Telephone #:______________________ Fax #:________________

Do you have a copy of the police report? ❑ Yes ❑ No **If yes, please provide us with a copy**

ATTORNEY REPRESENTATION:

Have you retained an attorney? ❑ Yes ❑ No

Attorney Name:____

Law firm Name:____

Address:____ Suite:________

State:_________ Zip:___________ Telephone #:____________________ Fax #:________________

The following points are important that you read and agree to in order for you to become a patient at our clinic.

- All services rendered will be considered cash until your insurance is verified.
- If you are unable to keep your appointment, we require that you call ahead to cancel so that someone else, if need can be put in your appointed time.
- Payment for services rendered that day are due before we leave unless other financial arrangements have been made.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. I understand that Chiro 1 Express will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit Chiro 1 Express to endorse remittances on my behalf. However, I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate treatment, payment in full may become due and payable immediately. Furthermore, I understand that should my account for any reason become delinquent, I may be responsible for including but not limited to collection agency fees, court costs, legal fees and interest.

Patient
Signature:____Date:____________________

Patient Name:____________________________

AUTO ACCIDENT INFORMATION:

Date of Accident:___________________ Time:______________ AM/PM
City:______________________________ State:_________
Driver of the car:____
Who owns the vehicle?____
Year, Make & Model of your car:____
Year, Make & Model of other car:____
Where were you seated? ❑ Driver ❑ Front center passenger ❑ Front right passenger
❑ Rear left passenger ❑ Rear center passenger ❑ Rear right passenger ❑ Pedestrian
Road conditions at time of accident: ❑ Wet ❑ Dry ❑ Icy ❑ Clear ❑ Other________________
Visibility at time of accident: ❑ Good ❑ Fair ❑ Poor ❑ Other_____________
Were you wearing your seatbelt? ❑ Yes ❑ No Does your car have headrest? ❑ Yes ❑ No
Did your head hit the head rest? ❑ Yes ❑ No Did you see the accident coming? ❑ Yes ❑ No
Did you brace for the impact? ❑ Yes ❑ No Airbags deployed ❑ Yes ❑ No ❑ Driver ❑ Front ❑ Side
At the time of the impact, was your vehicle: ❑ Stopped ❑ Moving
If moving how fast would you estimate you were going? __________ mph
How fast would you estimate the other car was going? ___________ mph
Did the vehicle flip over? ❑ Yes ❑ No Were you thrown out of your seat? ❑ Yes ❑ No
Were you hit from: ❑ Behind ❑ Front ❑ Left Side ❑ Right Side
In your own words describe the accident:____
____
Did you strike anything in the vehicle at time of impact? ❑ Yes ❑ No
If yes, what?____
Did you receive any cuts or lacerations? ❑ Yes ❑ No
If yes, where?____
Did you sustain any bruising as a result of this accident? ❑ Yes ❑ No
If yes, where?____
Head or body position at the time of impact: ❑ Head straight ahead ❑ Head turned to left/right ❑ Head looking back ❑ Body straight in sitting position ❑ Body rotated left/right ❑ Other______________________
As a result of the accident you were: ❑ Unconscious ❑ Dazed ❑ In Shock ❑ Unphased
Were you able to walk unaided after the accident ❑ Yes ❑ No
If no, why not?____
Did you feel immediate pain? ❑ Yes ❑ No
If yes, where?____
Did you go to the emergency room/hospital after the accident? ❑ Yes ❑ No
If yes were you taken by: ❑ Ambulance ❑ Driven by another person ❑ Able to take yourself
Hospital / Clinic Name:____
Dr. Name(s)____
____
What treatment was given? ❑ none ❑ x-rayed ❑ given stitches ❑ given pain medication
❑ placed in a cervical collar ❑ given instructions regarding sprains and strains
❑ Other ________________________________
If x-rays what area(s)____
Please describe how you felt: Immediately after the accident:_______________________
____
The next day:____
Have you seen any other doctor for this accident? ❑ Yes ❑ No
If yes, what treatment was given:____
____
Are you still treating with him/her? ❑ Yes ❑ No

Confidential Health History

LAST NAME, FIRST:	DATE:

MEDICATIONS: List medications you are currently taking	ALLERGIES : List all allergies

HOSPITALIZATIONS / FRACTURE BONES				PREGNANCIES	
YEAR	HOSPITAL	REASON	YEAR	SEX	COMPLICATIONS

Have you ever had a blood transfusion: ☐ Yes ☐ No		Check (√) which substances you use and how much		
If YES, give reason and dates:			Caffeine	
			Tobacco	
			Drugs	
SERIOUS ILLNESS / INJURIES	DATE			
		Check (√) if your job exposes you to :		
			Stress	
			Heavy Lifting	
			Other	

FAMILY HISTORY:					Check (√) BELOW AND INDICATE RELATION		
RELATION	AGE	STATE OF HEALTH	Age at death	Cause of Death		Disease	Relationship
FATHER						ARTHRITIS	
MOTHER						GOUT	
BROTHERS						CANCER	
						CHEMICAL DEPENDENCY	
						DIABETES	
SISTERS						STROKE	
						HIGH BLOOD PRESSURE	

Patient Signature: Date:

DO NOT WRITE BELOW THIS LINE PHYSICIAN USE ONLY

☐ MACRO 1 PMHX	☐ MACRO 11 PMHX	☐ MACRO 2 PSHX	☐ MACRO 22 PSHX
☐ MACRO 3 SFHX	☐ MACRO 33 SFHX	☐ MACRO 4 MEDS	☐ MACRO 44 MEDS
☐ MACRO 6 Drug	☐ MACRO 66 Drug		

Physician Initials

Confidential Health History

LAST NAME	FIRST	DATE: / /
Age:	Date of Birth / /	

SYMPTOMS: ***CHECK (√) ANYTHING YOU HAVE NOW OR HAVE HAD IN THE LAST YEAR***

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headaches
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINTS

Pain,weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Loss of Bladder Control
- ☐ Painful Urination

GASTROINTESTINAL
- ☐ Appetite Poor
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indegestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Heart beat
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Rapid heart Beat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

Eye Ear Nose Throat
- ☐ Bleeding Gums
- ☐ Blurred vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earache
- ☐ Ear Discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision Flashes
- ☐ Vision - Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in Moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

Men only
- ☐ Breast Lump
- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Penis Discharge
- ☐ Sore on Penis

Women Only
- ☐ Abnormal PAP
- ☐ Bleeding between periods
- ☐ Breast Lump
- ☐ Extreme Menstral Pain
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ Vaginal Discharge
- ☐ Other___________________

Date of Last period_____________________

Date of last PAP test__________________

Have you had a mamogram?_____________

Are you pregnant?______________

Number of Children____________

CONDITIONS: CHECK (√) ANYTHING YOU HAVE NOW OR HAVE EVER HAD

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulemia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measels
- ☐ Migraines
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problems
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infection
- ☐ Venereal Disease

DO NOT WRITE BELOW THIS LINE PHYSICIAN USE ONLY

- ☐ MACRO 5 ROS ☐ MACRO 55 ROS
- ☐ MACRO 1 PMHX ☐ MACRO 11 PMHX

Physician Initials

INITIAL PATIENT SYMPTOM QUESTIONNAIRE

PATIENT NAME:	TODAY'S DATE:	Age: Ht:
CHART NO.:	DATE OF ACCIDENT:	Wt: Sex: M / F

Check the box or boxes below If you ever experience the symptom(s) indicated as a result of your injuries.	How bad is your pain? Circle a number that best describes your pain when it is at its worst. 1 is mild pain 10 is the worst pain.	How often do you experience the symptom checked? Check the box that best describes how often you experience your pain.
☐ HEADACHES	1 2 3 4 5 6 7 8 9 10	☐ CONSTANT ☐ FREQUENT ☐ INTERMITTENT ☐ OCCASSIONAL
☐ NECK PAIN	1 2 3 4 5 6 7 8 9 10	☐ CONSTANT ☐ FREQUENT ☐ INTERMITTENT ☐ OCCASSIONAL
☐ MID BACK PAIN	1 2 3 4 5 6 7 8 9 10	☐ CONSTANT ☐ FREQUENT ☐ INTERMITTENT ☐ OCCASSIONAL
☐ LOW BACK PAIN	1 2 3 4 5 6 7 8 9 10	☐ CONSTANT ☐ FREQUENT ☐ INTERMITTENT ☐ OCCASSIONAL
☐ Right SHOULDER PAIN	1 2 3 4 5 6 7 8 9 10	☐ CONSTANT ☐ FREQUENT ☐ INTERMITTENT ☐ OCCASSIONAL
☐ Left SHOULDER PAIN	1 2 3 4 5 6 7 8 9 10	☐ CONSTANT ☐ FREQUENT ☐ INTERMITTENT ☐ OCCASSIONAL
☐ Right KNEE PAIN	1 2 3 4 5 6 7 8 9 10	☐ CONSTANT ☐ FREQUENT ☐ INTERMITTENT ☐ OCCASSIONAL
☐ Left KNEE PAIN	1 2 3 4 5 6 7 8 9 10:	☐ CONSTANT ☐ FREQUENT ☐ INTERMITTENT ☐ OCCASSIONAL
☐ Numbness/Tingling Right Arm/Hand	1 2 3 4 5 6 7 8 9 10	☐ CONSTANT ☐ FREQUENT ☐ INTERMITTENT ☐ OCCASSIONAL
☐ Numbness/Tingling Left Arm/Hand	1 2 3 4 5 6 7 8 9 10	☐ CONSTANT ☐ FREQUENT ☐ INTERMITTENT ☐ OCCASSIONAL
☐ Numbness/Tingling Right Leg/Foot	1 2 3 4 5 6 7 8 9 10	☐ CONSTANT ☐ FREQUENT ☐ INTERMITTENT ☐ OCCASSIONAL
☐ Numbness/Tingling Left Leg/Foot	1 2 3 4 5 6 7 8 9 10	☐ CONSTANT ☐ FREQUENT ☐ INTERMITTENT ☐ OCCASSIONAL
☐ _______________	1 2 3 4 5 6 7 8 9 10	☐ CONSTANT ☐ FREQUENT ☐ INTERMITTENT ☐ OCCASSIONAL
☐ _______________	1 2 3 4 5 6 7 8 9 10	☐ CONSTANT ☐ FREQUENT ☐ INTERMITTENT ☐ OCCASSIONAL

Patient Signature:_________________________________ **Date**: ____________________

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Examiner Initials: ________________

PATIENT NAME	TODAY'S DATE:

PLEASE CHECK THE BOX NEXT TO ANY SYMPTOM WHICH YOU EXPERIENCE:

☐ BLURRED VISION ☐ DIZZINESS ☐ IMBALANCE ☐ DYSCOORDINATION

☐ SHORT TERM MEMORY LOSS ☐ NERVOUSNESS WHEN IN VEHICLES ☐ FATIGUE

☐ DIFFICULTY SLEEPING ☐ INCREASED PAIN IN THE MORNING ☐ LOSS OF ENERGY

☐ ANXIETY ☐ INCREASED PAIN IN COLD/DAMP WEATHER

☐ PAIN DURING SEXUAL ACTIVITY

PLEASE CHECK THE BOX NEXT TO ANY OF THE FOLLOWING WHICH CAUSE YOU INCREASED PAIN.

☐ ATTEMPTNG TO LIFT OBJECTS ☐ BENDING NECK FORWARD ☐ BENDING NECK BACKWARDS

☐ BENDING FORWARD ☐ LEANING/BENDING BACKWARD

☐ EXTENDING ARMS OVERHEAD ☐ PUSHING HEAVY OBJECTS (DOORS, SHOPPING CARTS)

☐ STRAINING TO MOVE BOWELS ☐ PROLONGED SITTING ☐ PROLONGED STANDING

☐ COUGHING OR SNEEZING ☐ WALKING ☐ ASCENDING/DESCENDING STAIRS

☐ DRIVING ☐ CHILDCARE ☐ HOUSEHOLD DUTIES

☐ READING/PAPERWORK/COMPUTER WORK

PLEASE WRITE ANY ADDITONAL INFORMATION YOU WISH TO ADD:

____
____
____
____
____
____
____

Patient Signature:____ **Date**: ______________________________

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	Macro 13 PE ☐

Examiner Initials: ___________________