CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_____

Patient Name _____

Address _____

City/State/Zip _____

EMAIL: _____

Sex □ M □ F DOB _____

Age _____ Marital Status ____S ____M ____D ____W

Spouse's Name: _____

Social Security# _____

Home Phone (_____) _____

Cell Phone (_____) _____

Employer _____

Occupation _____

Employer Phone (_____) _____

DATE OF INJURY: _____

Attorney Name: _____

Attorney Phone (_____) _____

IN CASE OF AN EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Cell Phone (_____) _____

2 PAST HEALTH HISTORY

Previous Illnesses: _____

Previous Injuries or Trauma:_____

Have you ever had any broken bones? ☐ Y ☐ N

Previous Surgeries _____

ALLERGIES: _____

Last Menstrual Cycle: _____

Are you Pregnant? ☐ Y ☐ N If so, how many months?_____

FAMILY HISTORY

Please List any past illnesses or immediate family members:

(ex.: cancer, arthritis, diabetes, scoliosis, high blood pressure, etc)

TYPE OF ILLNESS	FAMILY MEMBER
_____	_____
_____	_____
_____	_____
_____	_____

HEALTH INSURANCE INFORMATION

Insurance: _____

Policy Number: _____

Group Number: _____

ID Number: _____

Member Name: _____

Deductible Met? ☐ Y ☐ N

How did you hear about us? □ Family/Friend _____ □ Radio □ Internet □ Mailing □ Other _____

3 PATIENT CONDITION

CHIEF COMPLAINT(S):_____

When did your symptoms appear? ___ Same day as accident ___ Day after accident ___ Two days after accident ___ 3 or more days

Treatment you have already received for condition? ___ Medication ___ Surgery ___ Physical Therapy ___Chiropractic Care ___ None

Type of pain? ___Sharp ___Dull ___Throbbing ___Numbness ___Aching ___Shooting

___Burning ___Tingling ___Cramps ___Stiffness ___Swelling ___Other

How often do you have the pain? _____ Is it constant or it comes and goes? _____

Does it interfere with your ___Work ___Sleep ___Daily Routine ___Recreation ___ School Activities

Activities or movements that are painful ___Sitting ___Standing ___Walking ___Bending ___ Lying Down

Name and address of doctor(s) or other healthcare practitioner(s) who have treated you for this condition:

Name _____

Address _____

Phone ( ) _____

Name _____

Address _____

Phone ( ) _____

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Today's Date _____

Patient Name _____ SS# _____ DOB _____

DATE OF ACCIDENT _____ Time _____am/pm

Please describe in your own words how the accident happened _____

_____

_____

_____

Were you the ____ Driver ____ Front Passenger ____ Rear Passenger ____ Pedestrian ____ Bicycle ____ Motorcycle

ACCIDENT SITE

Road/Street Name _____

City/State _____

Nearest intersection to road/street _____

VEHICLE

Make & Model of vehicle you were in _____

Were you wearing a seatbelt? ____Y ____N

If yes, what type? ____Lap & Shoulder ____Lap ____Shoulder

Was vehicle equipped with airbags? ____Y ____N

If yes, did it/they inflate properly? ____Y ____N

IMPACT

Did your car impact another vehicle? ____Y ____N

Did your car impact a structure? ____Y ____N

If yes, please explain_____

Did your body strike anything in the vehicle?

____Y ____N If So, What _____

Was impact from ___Front ___Rear ___Right ___Left

Were you braced for the impact? ___Y ___N

At the time of impact were you thrown:

____ Forward ____Backward ____ Right ____Left

POLICE

Did the police come to the scene of accident? ____Y ____N

Was a police report filed? ____Y ____N

If yes, Police Dept? _____

Were there any witnesses? ___Y ____N

Was a traffic violation issued? ____Y ____N

If yes, to whom? _____

Amount of Property Damage to your vehicle? _____

INSURANCE INFORMATION

Insurance Company _____

Policy Number _____

Name of Insured/Driver _____

Claim Number _____

Adjustor's Name _____

Adjustor's Phone _____

Adjustor's Fax _____

TREATMENT

Did you lose consciousness? _____Y _____N Did you go to the hospital? ____Y ____N

If yes, Name of Hospital _____

When did you go to hospital? ____Immediately after accident ____ Next Day ____ 2 or more days after accident

How did you get to the hospital? ____Ambulance ____Drove Yourself ____Family or Friend

Did the hospital take X-rays? ____Y ____N If yes, of what _____

Diagnosis _____

Treatment Received _____

Medication Prescribed _____

Any CT Scan Done? ____Y ____N If yes, of what _____

Any MRI Done? ____Y ____N If yes, of what _____