

Is there anything you do that makes your condition worse? _____

How has this condition affected your life?

- A. Home life _____
- B. Occupational life _____
- C. Recreational life _____
- D. Rest and Sleep life _____

Have you ever been in an automobile accident? Past year Past 5 years Over 5 years Never

ANY ACCIDENTS, FALLS, ETC., THAT MIGHT HAVE CAUSED YOUR PROBLEM _____

ANY MEDICAL DIAGNOSIS OF YOUR COMPLAINT _____

What surgery has been done? _____

Are you pregnant? Yes No

DRUGS YOU NOW TAKE Nerve Pills Pain Killers Muscle Relaxers "Pep" Pills Tranquilizers Insulin
 Birth Control Pills Other (please list) _____

ANY CHIROPRACTOR CONSULTED IN THE PAST? Name: _____

Dates consulted: _____ For what problem? _____

Fees are payable at the time x-rays, examinations, and treatments are received, unless other arrangements are made in advance. X-rays remain the property of this clinic.

Patient's Signature _____ Social Security No. _____ Date _____

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING QUESTIONS

Date of accident: _____ Hour: _____ AM _____ PM Location: _____

How did accident occur? Auto Collision On-the-Job Injury Other _____

If not an auto collision, please describe the circumstances: _____

Did you report the injury to your foreman or employer? Yes No

Did he (they) recommend care at our office? Yes No

If an auto accident, were you Driver? Passenger? Pedestrian?

If auto collision were you struck from Behind? Right Side? Left Side? Front? Auto was parked

Did your car strike the other(s) involved? Yes No Or did the other car strike yours? Yes No Undetermined

As a result of the accident, were traffic citations issued to you? Yes No To the driver of the other car? Yes No

To the driver of your car? Yes No List the extent of the injuries as you know them. _____

Did you require post-accident hospitalization? Yes No

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Light bothers Eyes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> _____ |

Symptoms other than above _____

Have you lost any days of work? Yes No Dates: _____

Name of Your Insurance Company Involved: _____

Name of Insurance Company of person responsible for injuries: _____

Have you been contacted by an Insurance Adjuster or Company representative regarding this claim? Yes No

Do you have an attorney who has advised you in this case? Yes No Name: _____

Address of attorney _____ Phone No. _____