



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. \_\_\_\_\_