Personal Injury Intake Form and Chiropractic Care Agreement

Patient Information

Today's Date _____ Home Phone _____
Name _____ Work Phone _____
Address _____ Email _____
_____ Social Security # _____
_____ Date of Birth _____
Sex _____ Height _____ Weight _____
Occupation _____ Marital Status _____
Employer _____
Address _____
If minor, name of parent or guardian Number of Children _____
_____
Who should we contact in case of emergency _____
Relation _____ Phone _____
Address _____
Attorney _____ Phone _____
Primary Doctor _____ Phone _____
How did you hear about our office? _____
Have you ever been to a chiropractor before? **Yes/No** If so, when? _____

Health Insurance Information

Insurance Company _____
Policy Holder's Name _____ Policy Number _____
Relationship to Policy Holder _____
Address _____ Phone _____

Auto Insurance Information

Insurance Company _____ Policy Number _____
Address _____ Phone _____
Adjustor's Name _____ Claim # _____

Accident Information

Date: _____ Time: _____ Was it reported to the police? **Yes/No**
Was a traffic violation issued? **Yes/No** To whom? _____
Is there a police report? **Yes/No**
Location of accident (Street, Town) Number of other passengers _____
_____
Make and mode of vehicle Were there other witnesses? **Yes/No**
_____

Accident Information (Continue)

Please, explain in detail how the accident occurred

_____

_____

_____

Select any of the following feelings that you experienced at the time of the accident?

CONFUSED	**DISORIENTED**	**LIGHT-HEADED**
DIZZY	**NAUSEATED**	**BLURRED VISION**
RINGING/BUZZING IN EARS	**LOSS OF BALANCE**	

Other _____

Do you still have any of these symptoms? **YES/NO** Is yes, which ones?

_____

Did the impact to your vehicle come from the: **FRONT REAR RIGHT LEFT OTHER**

During impact, were you facing: **RIGHT LEFT FORWARD**

Were you **AWARE** or **SURPRISED** by the impact?

Were you the **DRIVER FRONT SEAT PASSENGER BACK SEAT PASSENGER**?

In which direction were you headed? **N S E** W Driving how fast? _____

Were you wearing a seat belt? **Yes/No SHOULDER HARNESS? LAP HARNESS?**

Was the seat adjustment altered by the impact? **Yes/No**

Was the seat belt altered by the impact? **Yes/No**

Was the seat belt broken by the impact? **Yes/No**

Was the vehicle equipped with air bags? **Yes/No** Did they inflate? **Yes/No**

In relation to the base of your skull, where was the headrest? **ABOVE BELOW AT BASE**

Where were your hands? **One on the steering wheel? Both on the steering wheel? NA**

Were you wearing a hat or glasses at the time of the impact? **Yes/No**

Were either the hat or glasses still on after the impact? **Yes/No**

What did the vehicle impact? **ANOTHER VEHICLE OTHER**

What was the direction of the other vehicle was traveling? **N S E W**

What was the speed the other vehicle was traveling? **Speed _____**

If another vehicle, what was the make/model? _____

Did any part of your body strike anything in the vehicle? **Yes/No Explain:**

_____

Did the accident render you unconscious? **Yes/No If yes, for how long?**

How did you get there? **AMBULANCE PRIVATE TRANSPORTATION**

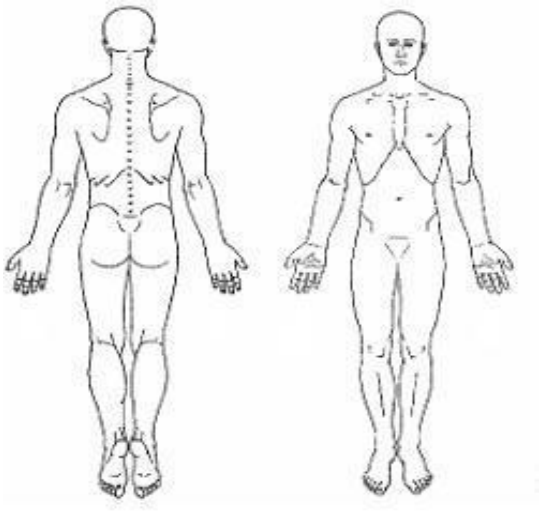
Post-Injury Information

Have you seen any other doctor(s) since the accident? **Yes/No**
If so, what are the doctor(s) names? _____
When did you go? **IMMEDIATELY NEXT DAY 2 DAYS PLUS**
Name of hospital and/or attending doctor: _____
Was he/she a: **D.C. M.D. D.O. D.D.S. ?**
Please, describe any treatment(s) you received:
_____
_____
Were X-Rays done? **Yes/No** An MRI? **Yes/No** CAT Scan? **Yes/No**
Was medication prescribed? **Yes/No** If yes, what? _____
What was the doctor(s) diagnosis? _____
What did the doctor(s) recommend for follow-up care? _____
Have you missed any work since the accident? **Yes/No NA** If so, dates? _____
Are your work activities restricted as a result of your injury? **Yes/No NA**
Indicate the symptoms that are a result of this accident:

DIZZINESS	**DIFFICULTY SLEEPING**	**JAW PROBLEMS**	**NAUSEA**
MEMORY LOSS	**ARM/SHOULDER PAIN**	**IRRITABILITY**	**UPPER BACK PAIN**
HEADACHES	**NUMB HANDS/FINGERS**	**FATIGUE**	**LOW BACK PAIN**
BLURRED VISION	**TENSION**	**CHEST PAIN**	**BACK STIFFNESS**
BUZZING IN EAR	**NECK PAIN**	**SHORT BREATH**	**LEG PAIN**
EARS RINGING	**STIFF NECK**	**UPSET STOMACH**	**NUMB FEET/TOES**
LOSS OF SMELL	**URINARY PROBLEMS**	**PINCHED NERVE**	**FEVER**
PARALYSIS	**DIFFICULTY SWALLOWING**	**DEPRESSION**	**LOSS OF SLEEP**
NERVOUSNESS	**DIGESTING PROBLEMS**	**SCIATICA**	**FAINTING**
LOSS OF BALANCE			

OTHER _____

Indicate where your symptoms are located, and rate from 1-10



None **Unbearable**
0 1 2 3 4 5 6 7 8 9 10

Post-Injury Information (Continue)

Does anything relieve your symptoms? **ICE HEAT STRETCHES REST MEDICATIONS**
What is the frequency of these symptoms?
___Constant ___ 75% of the time ___50% of the time ___25% of the time ___Rare
What is the nature of these symptoms?
___Sharp ___Dull ache ___Numb ___Shooting ___Burning ___Tingling ___Other
Which phrase best describes changes in your symptoms throughout the day:
___Worse in morning ___Worse in afternoon ___Worse at night
___Changes with weather ___ Worse with movement ___Worse with rest ___Does not change
Did you ever experience similar symptoms prior to the accident? **Yes/No**
Has your condition **IMPROVED WORSENED or STAYED THE SAME** since the accident?
Is your condition affecting your **WORK, SLEEP, or DAILY ROUTINE?** Please, explain

_____

_____

Are your work activities restricted as a result of your injury? **Yes/No NA**
How many hours are in your normal workday? _____
Indicate your daily job duties and any activities that you are occasionally asked to perform:

STANDING	**OPERATING EQUIPMENT**	**DRIVING**	**SITTING**
TWISTING	**WORK W/ARMS ABOVE HEAD**	**WALKING**	**CRAWLING**
TYPING	**LIFTING**	**BENDING**	**STOOPING**

What positions can you work in, with minimum physical effort, and for how long?

_____

Do you work with others who can help you with any heavy lifting? **Yes/No**
While in recovery, are there any light duty tasks you could request? Y**es/No**

Health History

List any general health issues you have _____

_____

Have you ever had any of the following diseases or conditions?

HEART ATTACK OR STROKE	**HEART SURGERY/PACEMAKER**	**HEART MURMUR**
CONGENITAL HEART DEFECT	**MITRAL VALVE COLLAPSE**	**ARTIFICIAL VALVES**
ALCOHOL/DRUG ABUSE	**VENEREAL DISEASE**	**HEPATITIS**
HIV+/AIDS	**SHINGLES**	**CANCER**
FREQUENT NECK PAIN	**EMPHYSEMA**	**ANEMIA**
HIGH/LOW BLOOD PRESSURE	**PSYCHIATRIC PROBLEMS**	**RHEUMATIC FEVER**
SEVERE/FREQ HEADACHES	**KIDNEY PROBLEMS**	**ULCERS/COLONITIS**
FAINTING/SEIZURE/EPILEPSY	**SINUS PROBLEMS**	**ASTHMA**
DIABETES	**DIFFICULTY BREATHING**	**TUBERCULOSIS**
LOWER BACK PAIN	**ARTIFICIAL BONES/JOINTS**	**ARTHRITIS**

List any ***other*** medical conditions that you have or have ever had.

_____

Health History (Continue)

Do you have any congenital (from birth) conditions/abnormalities which may affect your injuries? **Yes/No**

If so, explain _____

List any allergies.

_____

_____

List previous surgeries and dates.

_____

_____

List any past motor vehicle accidents or traumas and dates.

_____

_____

Is there anything else about your health history or family health history that you feel is important to share?

_____

_____

Do you exercise? **Yes/No**

Are you on any special diet? **Yes/No**

Do you smoke? **Yes/No** If so, how much? How long?

Do you consume alcohol? **Yes/No**

Do you consume caffeine? Y**es/No**

Are you wearing: **ORTHOTICS? HEEL LIFTS? ARCH SUPPORTS?**

List any medications or vitamins your are currently taking?

Name_____ Freq _____ Dosage _____ What is it used for? _____

Name_____ Freq _____ Dosage _____ What is it used for? _____

Name_____ Freq _____ Dosage _____ What is it used for? _____

Name_____ Freq _____ Dosage _____ What is it used for? _____

Name_____ Freq _____ Dosage _____ What is it used for? _____

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Name_____ Freq _____ Dosage _____ What is it used for? _____

Name_____ Freq _____ Dosage _____ What is it used for? _____

For Women: Are you taking birth control? Y**es/No**

Are you pregnant? **Yes/No** If so, how far along? _____ Nursing? **Yes/No**

Is there any chance you could be pregnant? **Yes/No**

Date of last menstrual cycle_____

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Inner Sanctum Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company. I authorize payment of insurance benefits directly to Inner Sanctum Chiropractic. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and/or payors to secure the payment of benefits. However, I clearly understand that I am personally responsible for all costs of treatment rendered, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

Patient/Legal Guardian Signature **Date:**