Injury Information

Date: _____ DOI: _____

Name: _____ Age: _____ DOB: _____ Height: _____ Weight: _____

Gender: M / F: Handedness: R / L /A: Race_____ Occupation: _____FT / PT

Type of Injury: Auto ___ Work ___ Personal ___ Sports ___ Other _____Time _____AM/PM

Were others involved? Yes ___ No ___ if yes Names: _____

Please describe the incident in your own words: _____

_____

_____

_____

IF INJURY INVOVLED A VEHICLE (IF NOT SKIP TO HEAD POSTION)

Were you the driver? ___ Passenger ___ front seat ___ back seat ___ other ___

Year and Model of your vehicle_____ People in your vehicle _____

What direction were you traveling? N ___S___E___W___ Street _____

Where you stopped? Yes ____No ____ If no, your Est. speed____ Struck from the F ___R___P___D___

Year and Model of other vehicle(s)_____

What direction of other vehicle? N ___S___E___W___ Street _____

Where they stopped? Yes ____No ____ If no, their Est. speed_____ Struck from the F ___R___P___D___

_____

Road Conditions? Wet ___ Dry ___ Visibility? Good ___ Poor ___ Wearing a seat belt? Yes _____No _____

With shoulder harness? Yes _____No _____ Were you aware of the impending collision? Yes _____No_____

If yes, did you brace and how?_____ Did the air bags deploy? Yes _____No _____

Were the police notified? Yes ____No ____ If yes, was a report filed? Yes ____No ____

HEAD POSTION

Your head position at injury? _____ Did you lose consciousness? Yes _____No _____ If yes, please explain: _____

Were you taken anywhere by ambulance or private party? Yes ____No ____ If yes, please explain:

_____

Have you been treated by any health care provider(s) for your injuries?` Yes ____No ____ If yes please Provide names, initial dates and phone numbers: _____

_____

What types of treatments and/or medications have you received related to your injuries, if any?

_____

_____

Did your body collide with anything when your injuries occurred? Yes ____No ____ If yes, please explain:

_____

How did you feel immediately following the incident? _____

_____

Injury Information

Name: _____ Date of Birth: _____

How did you feel later that day? _____

_____

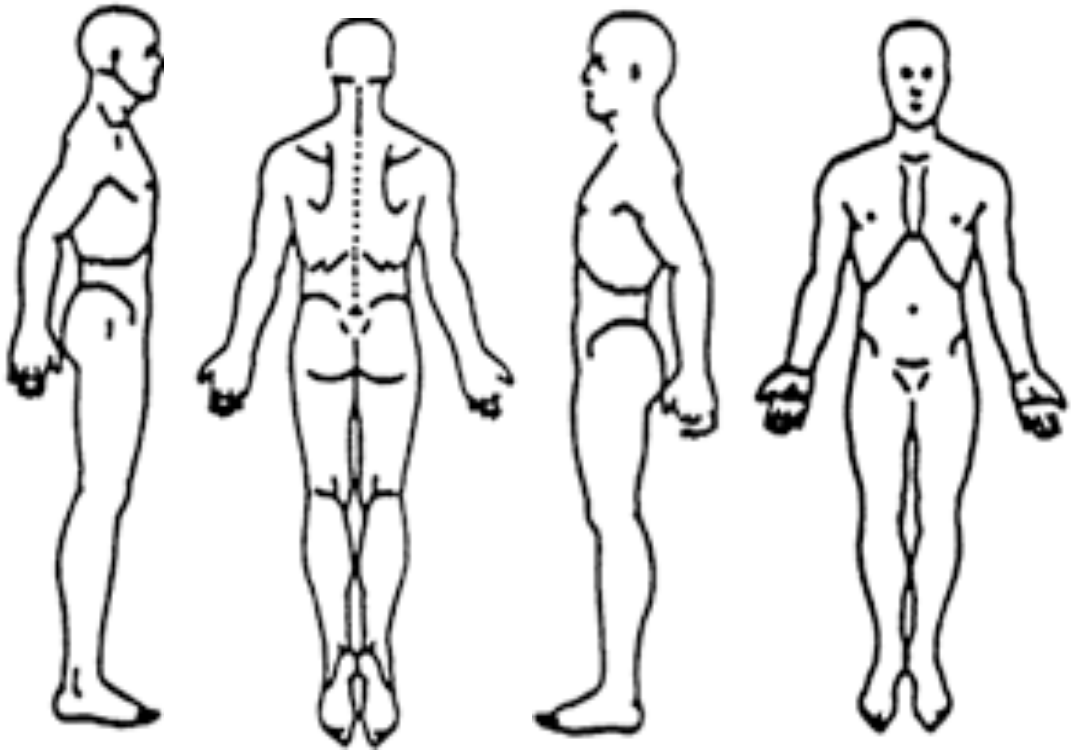
How did you feel the next day? _____

_____

How did you feel the following days? _____

_____

Please mark all areas of pain on the diagram:



Please list your current health concerns related to your injuries in order of priority:

_____

_____

Did your injuries occur while performing your job duties? Yes ____No ____ If yes, please explain:

_____

Has your condition impaired performing your job duties? Yes ____No ____ If yes, please explain:

_____

Have you lost time from work as a result of your injuries? Yes ____No ____ If yes, please explain:

_____

How do these condition(s) impair your daily activities? _____

_____

How do these condition(s) impair your social activities? _____

_____

Injury Information

Name: _____ Date of Birth: _____

What makes your condition it better? _____

What makes your condition it worse? _____

Did you have any health complaints prior to your injuries? Yes ____No ____ If yes, please explain:

_____

Name: _____ Date of Birth: _____

Have you ever had your current injuries before in this incident? Yes ____No ____ If yes, when and where?

_____

_____

If you have experience any of the following conditions in the past please mark (P) on the line provided.

If you are currently experiencing any of the following conditions please mark (C) on the line provided.

____Heart Attack	____Ringing in Ears	____Unexplained Weight Loss
____Stroke	____Asthma	____Unexplained Weight Gain
____High BP	____Diarrhea	____Recent Fever / Sweats
____Diabetes	____Constipation	____Chest Pains Discomfort
____Cancer	____Trouble Swallowing	____ Palpitations
____Arthritis	____Indigestion/Reflux	____ Shortness of Breath
____Kidney Stones	____ Abdominal Pain	____ Anxiety/Stress
____Gall Bladder	____Difficulty w/ Urination	____ Sleep Problems
____Prostate Problems	____Blood in Urine	____ Coughing /Wheezing
____Nausea/Vomiting	____Blood in Stool	____Change in Vision
____Dizziness	____Gout	____Glaucoma
____Headache	____Muscle pain	____Cold/Heat Intolerance
____Memory Loss	____Joint Replacement	____Increased Thirst
____Fainting	____Joint pain	
____Hearing Loss	____Unexplained Fatigue	

AUTHORIZATION

I certify that I have read and I understand the above information to the best of my knowledge. The questions aabove have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and reguest my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay Jess than the actual bill for services. I agree to be responsible forpayment of all services rendered on my behalf or my dependents.

Patient's Signature _____ Date_____

Guardian's Signature _____ Date_____