

Road conditions at the time of accident: Wet Dry Icy Other _____

Did the police come to the accident scene? Yes No Is there a report? Yes No

Did the EMS come to the accident scene? Yes No Did they evaluate you on scene? Yes No

Did you go to the hospital? Yes No If Yes, Which hospital? _____

How did you arrive there? Ambulance someone else drove I drove

Were parts of your body imaged at the hospital? Yes No Which? _____

Findings on images? Yes No Diagnosis? _____

What treatment was given? _____ Is it helping? Yes No

Was another doctor consulted after your accident? Yes No Doctor's name _____

Any other treatment? _____

Vehicle Description (for the vehicle you were in)

Year _____ Make _____ Model _____

Was your car stopped at the time of impact? Yes No

If "yes" was the driver's foot also on the brake? Yes No

If "no" please estimate the speed of the vehicle you were in _____ m.p.h.

If the vehicle was moving at the time of impact, was it: Slowing down? Yes No

Gaining speed? Yes No Traveling at a steady rate of speed? Yes No

Where was this vehicle impacted during the collision? _____

What is the cost damage to this vehicle? _____

What of the following car parts broke during the accident?:

Windshield Front seat back Right/left side window Steering wheel Other _____

Vehicle Description (for the other vehicle)

Year _____ Make _____ Model _____

Was the other vehicle stopped at the time of impact? Yes No

If "no" please estimate the speed that vehicle was moving _____ m.p.h.

If the vehicle was moving at the time of impact, was it: Slowing down? Yes No

Gaining speed? Yes No Traveling at a steady rate of speed? Yes No

Where was this vehicle impacted during the collision? _____

What is the cost damage to this vehicle? _____

What of the following car parts broke during the accident?:

Windshield Front seat back Right/left side window Steering wheel Other _____

Patient Name _____

DOB _____

Where were you seated in the vehicle you were in? _____ Were you aware of the approaching collision or did the impact catch you by surprise? _____ Did you attempt to brace for impact? Yes No

Did you hit your head? Yes No Did you lose consciousness (black out) upon impact? Yes No
If you did lose consciousness, estimate for how long _____

Were you wearing a seatbelt? Yes No lap seatbelt or shoulder-lap seatbelt (please circle) Any bruising from the belt? Yes No

Did your airbag deploy? Yes No

Any other bleeding or bruising obtained during this accident? Yes No _____

Any other body parts take an impact during this accident? Yes No _____

Which direction were you facing during the accident? _____

Check symptoms you have noticed since accident:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Heavy Head | <input type="checkbox"/> Tingling in Legs | <input type="checkbox"/> Tingling in Arms | <input type="checkbox"/> Numbness in fingers |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Eyes Sensitive to Light |
| <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Ringing of Ears | <input type="checkbox"/> Face Flushing | <input type="checkbox"/> Buzzing in Ears |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Fainting | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Loss of taste |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Upset Stomach |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Fever | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Tension | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Jaw Pain/Clicking |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Nausea/Vomiting | |

Have you lost time from work as a result of this accident? Yes No If yes, last day worked _____

Body region 1 (Most painful/problematic)

Please indicate in which region of the body you are having symptoms _____

Note any symptoms other than pain you notice in this region _____

Is there any pain radiating from this area and/or any numbness, tingling or weakness _____

On a 0-10 scale with 0 being no pain at all and 10 being the worse imaginable pain please rate the following for this area: Average pain intensity ____/10 Current pain intensity ____/10 Worst pain intensity ____/10

How often do you feel these symptoms _____ How long do these symptoms last with each episode: _____ What % of time you are having pain in this region _____%

If pain is intermittent, explain when and/or what brings it on? _____
When did you first notice symptoms in this area? _____

Patient Name _____

DOB _____

Body region 2

Please indicate in which region of the body you are having symptoms _____

Note any symptoms other than pain you notice in this region _____

Is there any pain radiating from this area and/or any numbness, tingling or weakness _____

On a 0-10 scale with 0 being no pain at all and 10 being the worse imaginable pain please rate the following for this area: Average pain intensity_____/10 Current pain intensity ___/10 Worst pain intensity ___/10

How often do you feel these symptoms _____ How long do these symptoms last with each episode: _____ What % of time you are having pain in this region _____%

If pain is intermittent, explain when and/or what brings it on? _____

When did you first notice symptoms in this area? _____

Body region 3

Please indicate in which region of the body you are having symptoms _____

Note any symptoms other than pain you notice in this region _____

Is there any pain radiating from this area and/or any numbness, tingling or weakness _____

On a 0-10 scale with 0 being no pain at all and 10 being the worse imaginable pain please rate the following for this area: Average pain intensity_____/10 Current pain intensity ___/10 Worst pain intensity ___/10

How often do you feel these symptoms _____ How long do these symptoms last with each episode: _____ What % of time you are having pain in this region _____%

If pain is intermittent, explain when and/or what brings it on? _____

When did you first notice symptoms in this area? _____

List up to 6 of your normal activities that your symptoms make difficult for you to complete. Rate your ability to perform these on a 0-10 scale with 10 being completely able to perform and 0 being completely unable to perform.

1) _____ Rating_____/10 2) _____ Rating_____/10

3) _____ Rating_____/10 4) _____ Rating_____/10

5) _____ Rating_____/10 6) _____ Rating_____/10

Have you seen a chiropractor before? _____ If yes, Whom/How did they adjust you/Were they effective/What do you wish they would have done differently _____

Patient Name _____

DOB _____

Any **weight change** not initiated by you over the past couple of months ____ How much _____

Night pain that wakes you from sleeping _____ **History of cancer** and When? _____

Any **bowel or bladder** changes recently/Explain _____

What are your **treatment goals** for this injury _____

Do you have any life events you are working toward _____

Any **major illnesses or hospitalizations or surgeries** _____

Any **general traumas** such as car accidents or sporting accidents _____

Have you ever been **knocked unconscious** ____ When _____

Any Hardware/Replacements? ____ **Where** _____

Did last physical include a PAP/Breast exam or Prostate check: Y/N **When:** ____ **Any Concerns/Positives?** ____

Medications/Supplements/Vitamins (including over-the-counter) _____

Family History of any health condition present or past (example: Cancer, heart disease, diabetes, arthritis, etc.) and when, and were they treated successfully? (Immediate family is most applicable here)

What is your **stress level** like from home _____ What is your **stress level** like from work _____

More emotional stressors or physical stressors? _____

How is your sleep _____ Any sleep aid use? _____

FEMALES ONLY Previous pregnancies? ____ Number ____ Difficulty with labors? ____ 1st day of last menstrual period ____ If in menopause; was it natural or surgically induced ____ If Surgical-Why? ____ Are you on hormone therapy? ____

Habits

Do you drink alcohol? _____ What do you drink and how often _____

Do you smoke or have you? _____ When did you start ____ How many per day ____ When did you quit _____

Any recreational drug use _____ What type ____ When did you start ____ Times per day _____

Do you drink Coffee? _____ Decaf or Regular? How many cups a day _____

Do you drink Soda? _____ Diet or Regular? Kind ____ How many per day _____

Do you drink Water? _____ How many glasses per day _____

Do you do any type of exercise? How often and for how long _____

How is your diet? _____

Any sugary foods? _____ How often do you have sugary foods _____

Any artificial sweeteners? _____ How often do you have these _____

How is your appetite? _____

Patient Name _____

DOB _____

Review of Systems Please mark the following for ongoing/current (C) or past (P)

GENERAL SYMPTOMS

- Tremors
- Twitching
- Convulsions
- Dizziness
- Depression
- Headache/Migraine
- Nervousness
- Numbness
- Fatigue

MUSCLES & JOINTS

- Low Back Problems
- Joint Dislocation
- Neck Problems
- Arm/Hand Problems
- Leg/Foot Problems
- Swollen Joints
- Painful Joints
- Stiff Joints
- Degenerative Disc Disease
- Disc Herniation
- Walking Problems
- Scoliosis
- Broken Bones
- Arthritis
- Sciatica

CARDIO-VASCULAR

- High Blood Pressure
- Heart Attack
- Chest Pain
- Poor Circulation
- Heart Trouble
- Rapid Heart
- Slow Heart
- Strokes
- Swelling Ankles
- Varicose Veins
- Fainting
- Low Blood Pressure
- Shortness of Breath
- Pacemaker

NEUROLOGICAL

- Anxiety
- Mood Swings
- Memory Loss
- Phobia
- Mental Disorder
- Multiple Sclerosis
- Epilepsy
- Balance Issue
- Cerebral Palsy

EAR/NOSE/THROAT

- Ear Discharge/Drainage
- Deafness
- Earache
- Ear Noises (ring/buzz)
- Thyroid Dysfunction
- Frequent Colds
- Jaw Problems
- Nasal Blockage
- Nose Bleeds
- Pain Behind Eyes
- Poor Vision/Blurred Vision
- Sinusitis
- Sore Throats
- Tonsillitis

GASTRO-INTESTINAL

- Belching/Gas
- Colon Problems
- Constipation
- Diarrhea
- Excessive Hunger
- Excessive Thirst
- Gall Bladder Trouble
- Hemorrhoids
- Liver Issue
- Weight Loss/Gain
- Nausea
- Abdominal Pain
- Ulcer
- Poor Appetite
- Poor Digestion
- Vomiting
- Heartburn
- Black Stool
- Bloody Stool
- Oily Stool
- Blood in Urine
- Hernia

SYSTEMIC

- Chills
- Fever
- Night Sweats
- Loss of Sleep
- AIDS/HIV
- Cancer
- Tuberculosis
- Hepatitis
- Diabetes
- Measles
- Loss of Smell/Taste
- Anemia

RESPIRATORY

- Bronchitis
- Emphysema
- Asthma
- Chronic Cough
- Difficulty Breathing
- Spitting Blood
- Spitting Phlegm
- Wheezing

GENITO-URINARY

- Blood in Urine
- Frequent Urination
- Kidney Infection/Stones
- Painful Urination
- Prostate Problems
- Loss of Bladder/Bowel Control
- Venereal Disease

SKIN OR ALLERGIES

- Bruising Easily
- Dryness
- Eczema/Rash/Dermatitis
- Hives
- Itching
- Sensitive Skin
- Allergy _____
- Gout
- Boils

FOR WOMEN ONLY

- Birth Control -hormonal
- Birth Control -physical
- Hormone Replacement
- Cramps/Backaches
- Excessive Flow
- Hot Flashes
- Irregular Cycle
- Miscarriage
- Painful Period
- Vaginal Discharge
- Breast Pain
- Pregnant at this Time Y/N
- Tubal Ligation
- Lumps in Breast

SYSTEMIC CONTINUED

- Mumps
- Polio
- Chicken Pox
- Rheumatic Fever
- Muscular Dystrophy
- Pleurisy
- Sensitive to Light/Sound
- Alcoholism

Patient Signature _____

Date _____