MOTOR VEHICLE ACCIDENT HISTORY

PATIENT DATA

TITLE: ❑ MR. ❑ MRS. ❑ MS. ❑ MISS (CHECK ONE) DATE:

FIRST NAME: MI: LAST NAME:

ADDRESS:

CITY: STATE: ZIP CODE:

HOME PHONE: CELL PHONE: WORK PHONE:

PRIMARY EMAIL:

BEST CONTACT METHOD (*Check One*) ❑ HOME PHONE ❑ CELL PHONE ❑ WORK PHONE

SS NUMBER: SEX: ❑ MALE ❑ FEMALE DOB: AGE:

EMPLOYMENT STATUS: ❑ EMPLOYED ❑ SELF EMPLOYED ❑ RETIRED ❑ FULL TIME STUDENT ❑ PART TIME STUDENT ❑ UNEMPLOYED ❑ OTHER_____

EMPLOYER NAME: OCCUPATION:

ADDRESS: CITY: STATE: ZIP:

MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ OTHER

IF MARRIED, PLEASE FILL OUT THE FOLLOWING FOR YOUR SPOUSE:

FIRST NAME: MI: LAST NAME:

PRIMARY PHONE NUMBER: IS YOUR SPOUSE A PATIENT IN THIS CLINIC? ❑ YES ❑ NO

CHILDREN: ❑ YES ❑ NO

IF YES, PLEASE LIST THEIR NAME AND AGE:

RACE (*Check One*):

❑ WHITE	❑ CHINESE	❑ ASIAN	❑ I CHOOSE NOT TO SPECIFY
❑ BLACK/AFRICAN AMERICAN	❑ JAPANESE	❑ ASIAN INDIAN	
❑ HISPANIC	❑ KOREAN	❑ OTHER _____	

MULTI-RACIAL (*Check One*): ❑ YES ❑ NO ❑ UNKNOWN

ETHNICITY (*Check One*): ❑ HISPANIC OR LATINO ❑ NOT HISPANIC OR LATINO ❑ I CHOOSE NOT TO SPECIFY

PREFERRED LANGUAGE (*Check One*):

❑ ENGLISH	❑ ITALIAN	❑ JAPANESE	❑ GERMAN
❑ SPANISH	❑ KOREAN	❑ CHINESE	❑ OTHER _____
❑ AMERICAN SIGN LANGUAGE	❑ RUSSIAN	❑ FRENCH	❑ I CHOOSE NOT TO SPECIFY

❑ I CHOOSE TO DECLINE RECEIPT OF MY CLINICAL SUMMARY AFTER EVERY VISIT (*These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

PRIMARY CARE PHYSICIAN NAME: PRACTICE NAME:

EMERGENCY CONTACT: PHONE: RELATIONSHIP:

HOW DID YOU HEAR ABOUT OUR CLINIC? OR WHO REFERRED YOU?

❑ FAMILY MEMBER ❑ FRIEND ❑ PHYSICIAN ❑ EMPLOYER ❑ ATTORNEY ❑ SIGN ON BUILDING ❑ INTERNET WEB SITE
❑ HEALTH CLASS ❑ BROCHURE ❑ OTHER _____

IF YOU SELECTED "FAMILY MEMBER, FRIEND, OR PHYSICIAN" PLEASE ENTER THEIR NAME:

INSURANCE INFORMATION (Important: If you are not the primary insured please fill out the following)

PRIMARYHEALTH INSURANCE

INSURANCE COMPANY:

INSURED'S NAME: RELATIONSHIP TO INSURED:

INSURED'S SOCIAL SECURITY #: INSURED'S BIRTHDATE:

INSURED'S EMPLOYER NAME:

ADDRESS: CITY: STATE: ZIP:

SECONDARY HEALTH INSURANCE

INSURANCE COMPANY:

INSURED'S NAME: RELATIONSHIP TO INSURED:

INSURED'S SOCIAL SECURITY #: INSURED'S BIRTHDATE:

INSURED'S EMPLOYER NAME:

ADDRESS: CITY: STATE: ZIP:

AUTO INSURANCE INFORMATION

INSURANCE COMPANY NAME:

INSURANCE COMPANY PHONE:

INSURANCE COMPANY ADDRESS:

CITY: STATE: ZIP CODE:

ADJUSTER NAME:

ADJUSTER PHONE:

POLICY NUMBER:

CLAIM NUMBER:

DO YOU HAVE AN ATTORNEY ON THIS CLAIM? ❑ YES ❑ NO

ACCIDENT INFORMATION

DATE OF ACCIDENT:	TIME OF ACCIDENT:	LOCATION OF ACCIDENT:	STATE ACCIDENT OCCURRED:
NUMBER OF PEOPLE IN THE CAR:	NAMES OF PEOPLE IN THE CAR WITH YOU:		

YEAR AND MODEL OF YOUR CAR:

YEAR AND MODEL OF OTHER CAR:

IN YOUR OWN WORDS, PLEASE DESCRIBE THE ACCIDENT:

_____

_____

_____

_____

_____

_____

_____

TYPE OF ACCIDENT:

❑ HEAD ON COLLISION ❑ BROAD SIDE COLLISION ❑ FRONT IMPACT

❑ REAR-END CAR IN FRONT ❑ REAR IMPACT ❑ NON-COLLISION

❑ RAN OFF ROAD INTO DITCH/EMBANKMENT ❑ OTHER _____

ON WHAT STREET WERE YOU HEADED?

AT THE TIME OF THE ACCIDENT, RECALL WHAT PARTS OF YOUR HEAD/BODY HIT WHAT PARTS ON THE INSIDE OF YOUR CAR:

_____

_____

WHAT DIRECTION WAS YOUR CAR HEADED?

❑ NORTH ❑ SOUTH ❑ EAST ❑ WEST

WHAT DIRECTION WAS THE OTHER CAR HEADED?

❑ NORTH ❑ SOUTH ❑ EAST ❑ WEST

DOES YOUR CAR HAVE A HEADREST? ❑ YES ❑ NO

IF YES, WHAT WAS THE POSITION OF THE HEADREST COMPARED TO YOUR HEAD?

❑ TOP OF HEADREST EVEN WITH BOTTOM OF HEAD

❑ TOP OF HEADREST EVEN WITH TOP OF HEAD

❑ TOP OF HEADREST EVEN WITH MIDDLE NECK

WERE YOU STRUCK FROM:

❑ SIDE ❑ BEHIND ❑ FRONT ❑ DRIVERS SIDE ❑ PASSENGERS

WHERE WERE YOU LOCATED IN THE VEHICLE AT THE TIME OF THE ACCIDENT?

❑ DRIVER ❑ PASSENGER ❑ FRONT SEAT ❑ BACK SEAT

ROAD CONDITIONS AT TIME OF ACCIDENT:

❑ ICY ❑ RAINY ❑ WET ❑ CLEAR ❑ DARK ❑ OTHER:

HEAD/BODY POSITION AT TIME OF IMPACT:

❑ HEAD TURNED LEFT/RIGHT ❑ BODY STRAIGHT IN SITTING POSITION
❑ HEAD LOOKING FORWARD ❑ BODY ROTATED LEFT/RIGHT
❑ HEAD LOOKING BACK ❑ OTHER: _____

DID YOU SEE THE ACCIDENT COMING? ❑ YES ❑ NO

DID YOU BRACE FOR IMPACT? ❑ YES ❑ NO

DID YOU HIT YOUR HEAD? ❑ YES ❑ NO

WERE SEATBELTS WORN? ❑ YES ❑ NO

WERE SHOULDER HARNESSES WORN? ❑ YES ❑ NO

WAS YOUR CAR BRAKING? ❑ YES ❑ NO

PLEASE DESCRIBE HOW YOU FELT:

IMMEDIATELY AFTER THE ACCIDENT: _____

LATER THAT DAY: _____

THE NEXT DAY: _____

WAS YOUR CAR MOVING AT THE TIME OF THE ACCIDENT? ❑ YES ❑ NO

IF YES, HOW FAST DO YOU ESTIMATE YOU WERE GOING? _____ MPH

HOW FAST DO YOU ESTIMATE THE OTHER CAR WAS GOING? _____ MPH

AS A RESULT OF THE ACCIDENT WERE YOU:

❑ RENDERED UNCONSCIOUS ❑ DAZED, CIRCUMSTANCES VAGUE

❑ IN SHOCK ❑ OTHER: _____

HOW WAS THE SHOULDER HARNESS ADJUSTED? ❑ LOOSE ❑ SNUG

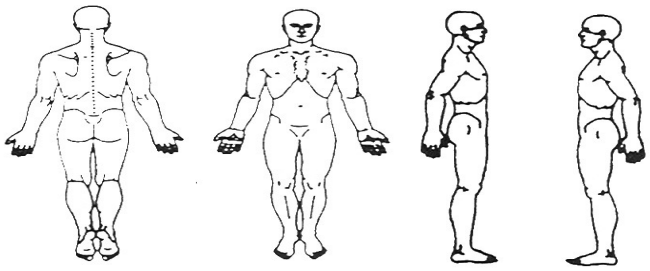
DID YOU GET ANY BRUISES/CUTS? ❑ YES ❑ NO
IF YES, WHERE _____

DOCTOR NOTES:

Name: _____

Health Concern #1

INDICATE ON THE BODY DIAGRAM WHERE YOU ARE EXPERIENCING SYMPTOMS:



INDICATE THE AVERAGE INTENSITY OF EACH OF YOUR SYMPTOMS:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
NO PAIN UNBEARABLE

WHEN DID YOUR SYMPTOMS START?

HOW DID YOUR SYMPTOMS BEGIN?

HOW OFTEN DO YOU EXPERIENCE YOUR SYMPTOMS?

- ❑ CONSTANTLY (76%-100% OF THE DAY)
- ❑ FREQUENTLY (51%-75% OF THE DAY)
- ❑ OCCASIONALLY (26%-50% OF THE DAY)
- ❑ INTERMITTENTLY (0%-25% OF THE DAY)

WHAT DESCRIBES THE NATURE OF YOUR SYMPTOMS?

- ❑ DULL ❑ SHARP ❑ SHARP WITH MOVEMENT ❑ THROBBING
- ❑ BURNING ❑ DEEP ❑ ACHING ❑ TINGLING
- ❑ STABBING ❑ CRAMPING ❑ PINPRICK ❑ NUMBNESS

DOES YOUR PAIN RADIATE? ❑YES ❑NO
IF YES, WHERE?

ARE YOUR SYMPTOMS:

- ❑ THE SAME ALL THE TIME
- ❑ WORSE: □ A.M. □ MIDDAY □ P.M. □ AT NIGHT □ AT NIGHT WITH PAIN
- ❑ BETTER: □ A.M. □ MIDDAY □ P.M. □ AT NIGHT □ AT NIGHT WITH PAIN

WHAT ACTIVITIES AGGRAVATE YOUR SYMPTOMS?

- ❑ SITTING ❑ STANDING ❑ WALKING ❑ BENDING
- ❑ STAIR STEPPING ❑ LIFTING ❑ SLEEPING ❑ SNEEZING
- ❑ LOOKING UP ❑ STRAINING ❑ REACHING ❑ TWISTING
- ❑ LOOKING DOWN ❑ COUGHING ❑ MOVEMENT ❑ REST
- ❑ LYING SUPINE ❑ DRIVING ❑ TYPING ❑ SCOOPING
- ❑ HOUSEHOLD CHORES ❑ EXERCISE ❑ STOOPING ❑ OTHER:_____

WHAT RELIEVES YOUR SYMPTOMS?

- ❑ SITTING ❑ STANDING ❑ LYING DOWN
- ❑ LEANING AGAINST A SUPPORT ❑ NO MOVEMENT ❑ MOVEMENT
- ❑ HEAT IS APPLIED ❑ ICE IS APPLIED ❑ REST OCCURS
- ❑ ADVIL/TYLENOL IS TAKEN ❑ R/x MEDICATION ❑ ADJUSTMENTS
- ❑ TOPICAL PAIN RELIEF GEL ❑ STRETCHING ❑ EXERCISE
- ❑ OTHER: _____

HAVE YOU SEEN A CHIROPRACTOR IN THE PAST? ❑ YES ❑ NO

IF YES, WHO AND DATE OF LAST VISIT:

HAVE YOU CONSULTED OTHER PHYSICIANS FOR YOUR SYMPTOMS? ❑ YES ❑ NO
IF YES, LIST WHO, WHEN, AND WHAT TREATMENT:

HAVE THEY PERFORMED ANY OTHER TEST FOR YOUR SYMPTOMS?
❑ NONE ❑ X-RAYS ❑ MRI ❑ CT SCAN ❑ OTHER: _____

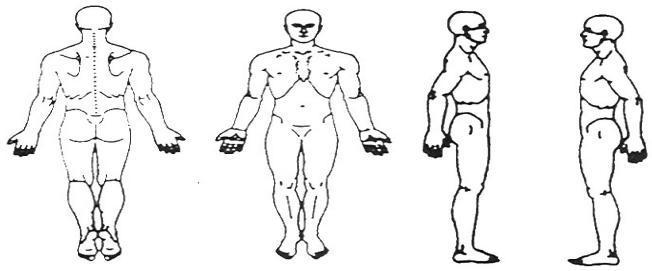
IF YES, WHEN AND WHERE:

HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? ❑YES ❑NO
IF YES, WHEN:

DOCTOR'S NOTES:

Health Concern #2

INDICATE ON THE BODY DIAGRAM WHERE YOU ARE EXPERIENCING SYMPTOMS:



INDICATE THE AVERAGE INTENSITY OF EACH OF YOUR SYMPTOMS:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
NO PAIN UNBEARABLE

WHEN DID YOUR SYMPTOMS START?

HOW DID YOUR SYMPTOMS BEGIN?

HOW OFTEN DO YOU EXPERIENCE YOUR SYMPTOMS?

- ❑ CONSTANTLY (76%-100% OF THE DAY)
- ❑ FREQUENTLY (51%-75% OF THE DAY)
- ❑ OCCASIONALLY (26%-50% OF THE DAY)
- ❑ INTERMITTENTLY (0%-25% OF THE DAY)

WHAT DESCRIBES THE NATURE OF YOUR SYMPTOMS?

- ❑ DULL ❑ SHARP ❑ SHARP WITH MOVEMENT ❑ THROBBING
- ❑ BURNING ❑ DEEP ❑ ACHING ❑ TINGLING
- ❑ STABBING ❑ CRAMPING ❑ PINPRICK ❑ NUMBNESS

DOES YOUR PAIN RADIATE? ❑YES ❑NO
IF YES, WHERE?

ARE YOUR SYMPTOMS:

- ❑ THE SAME ALL THE TIME
- ❑ WORSE: □ A.M. □ MIDDAY □ P.M. □ AT NIGHT □ AT NIGHT WITH PAIN
- ❑ BETTER: □ A.M. □ MIDDAY □ P.M. □ AT NIGHT □ AT NIGHT WITH PAIN

WHAT ACTIVITIES AGGRAVATE YOUR SYMPTOMS?

- ❑ SITTING ❑ STANDING ❑ WALKING ❑ BENDING
- ❑ STAIR STEPPING ❑ LIFTING ❑ SLEEPING ❑ SNEEZING
- ❑ LOOKING UP ❑ STRAINING ❑ REACHING ❑ TWISTING
- ❑ LOOKING DOWN ❑ COUGHING ❑ MOVEMENT ❑ REST
- ❑ LYING SUPINE ❑ DRIVING ❑ TYPING ❑ SCOOPING
- ❑ HOUSEHOLD CHORES ❑ EXERCISE ❑ STOOPING ❑ OTHER:_____

WHAT RELIEVES YOUR SYMPTOMS?

- ❑ SITTING ❑ STANDING ❑ LYING DOWN
- ❑ LEANING AGAINST A SUPPORT ❑ NO MOVEMENT ❑ MOVEMENT
- ❑ HEAT IS APPLIED ❑ ICE IS APPLIED ❑ REST OCCURS
- ❑ ADVIL/TYLENOL IS TAKEN ❑ R/x MEDICATION ❑ ADJUSTMENTS
- ❑ TOPICAL PAIN RELIEF GEL ❑ STRETCHING ❑ EXERCISE
- ❑ OTHER: _____

HAVE YOU SEEN A CHIROPRACTOR IN THE PAST? ❑ YES ❑ NO

IF YES, WHO AND DATE OF LAST VISIT:

HAVE YOU CONSULTED OTHER PHYSICIANS FOR YOUR SYMPTOMS? ❑ YES ❑ NO
IF YES, LIST WHO, WHEN, AND WHAT TREATMENT:

HAVE THEY PERFORMED ANY OTHER TEST FOR YOUR SYMPTOMS?
❑ NONE ❑ X-RAYS ❑ MRI ❑ CT SCAN ❑ OTHER: _____

IF YES, WHEN AND WHERE:

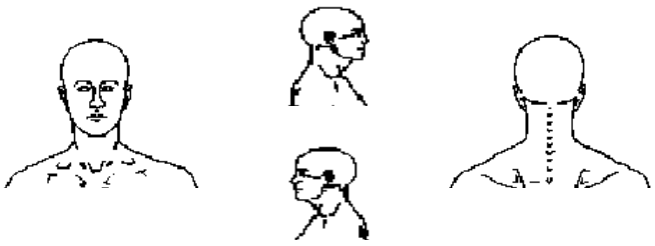
HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? ❑YES ❑NO
IF YES, WHEN:

DOCTOR'S NOTES:

Name: _____

Headaches

INDICATE ON THE BODY DIAGRAM WHERE YOU ARE EXPERIENCING SYMPTOMS:



WHAT IS THE INTENSITY OF YOUR HEADACHES ?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

NO PAIN WORST PAIN POSSIBLE

WHEN DID YOUR HEADACHES BEGIN?

ON AVERAGE, HOW OFTEN DO THEY OCCUR?

_____X/WEEK _____X/MONTH _____SPORADIC

WHAT DESCRIBES YOUR HEADACHES?

- ❑ DULL ❑ SHARP ❑ ACHING ❑ DEEP
- ❑ STABBING ❑ BURNING ❑ VICE-LIKE ❑ PRESSURE
- ❑ THROBBING/PULSATING ❑ OTHER _____

WHEN DO YOUR HEADACHES USUALLY START?

- ❑ WAKING IN MORNING ❑ DURING EVENING
- ❑ AT MID-DAY ❑ CONSTANT

WHAT SEEMS TO BRING ON YOUR HEADACHES?

- ❑ PHYSICAL ACTIVITY ❑ CAFFEINE
- ❑ EXCESSIVE STRESS ❑ CERTAIN FOODS
- ❑ ALCOHOL ❑ MENSTRUAL PERIOD
- ❑ SINUS CONGESTION ❑ OTHER:

HOW LONG DO YOUR HEADACHES LAST?

- ❑ < 1 HR ❑ 1-3 HRS ❑ >3 HRS ❑ ALL HRS
- ❑ SEVERAL HOURS ❑ OTHER:

DO YOUR HEADACHES WAKE YOU? ❑YES ❑NO

DO THE FOLLOWING OCCUR WITH YOUR HEADACHES?

- ❑ NAUSEA/VOMITING ❑ LIGHT/SOUND SENSITIVE
- ❑ WEAKNESS ❑ VISION PROBLEMS
- ❑ DIZZINESS ❑ TREMOR
- ❑ OTHER _____

WHAT MAKES YOUR HEADACHE BETTER?

- ❑ NOTHING ❑ REST
- ❑ LYING DOWN ❑ ICE/COLD PACKS
- ❑ MASSAGE ❑ STANDING
- ❑ NSAIDS (ASPIRIN, TYLENOL, ADVIL) ❑ OTHER:

HAVE YOU SEEN A CHIROPRACTOR IN THE PAST? ❑ YES ❑ NO
IF YES, WHO AND DATE OF LAST VISIT:

HAVE YOU CONSULTED ANY OTHER PHYSICIANS FOR YOUR SYMPTOMS? ❑ YES ❑ NO
IF YES, LIST WHO, WHEN, AND WHAT TREATMENT:

HAVE THEY PERFORMED ANY OTHER TEST FOR YOUR SYMPTOMS?
❑ NONE ❑ X-RAYS ❑ MRI ❑ CT SCAN ❑ OTHER: _____

IF YES, WHEN AND WHERE:

HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? ❑YES ❑NO
IF YES, WHEN:

DOCTOR'S NOTES:

Name: _____

MEDICAL CONDITIONS	
❑ ARTHRITIS	❑ HYPERTENSION
❑ CANCER TYPE:_____	❑ PSYCHIATRIC ILLNESS
❑ DIABETES	❑ SKIN DISORDER
❑ HEART DISEASE	❑ STROKE

SURGERIES (Check and List year)	
❑ APPENDECTOMY _____	❑ JOINT REPLACEMENT _____
❑ HEART _____	❑ NECK SURGERY _____
❑ LAMINECTOMIES _____	❑ BACK SURGERY _____
❑ PROSTATE SURGERY _____	❑ HYSTERECTOMY _____
❑ OTHER (DESCRIBE): _____	

ALLERGIES	
❑ EGGS	❑ SOY
❑ FISH AND SHELLFISH	❑ SULFITES
❑ MILK OR LACTOSE	❑ WHEAT/GLUTEN
❑ PEANUT	❑ OTHER: _____

SOCIAL HISTORY	
❑ CAFFEINE USED OCCASIONALLY	❑ CAFFEINE USED OFTEN
❑ CHEW TOBACCO OCCASIONALLY	❑ CHEW TOBACCO OFTEN
❑ DRINK ALCOHOL OCCASIONALLY	❑ DRINK ALCOHOL OFTEN
❑ EXERCISE NOT AT ALL	❑ EXERCISE OCCASIONALLY
❑ EXERCISE OFTEN	❑ EXPERIENCE STRESS OCCASIONALLY
❑ EXPERIENCE STRESS OFTEN	❑ WEAR SEAT BELTS ALWAYS
❑ WEAR SEAT BELTS NEVER	❑ WEAR SEAT BELTS USUALLY

SUBSTANCE ABUSE	
❑ ALCOHOL (PAST)	❑ ALCOHOL (PRESENT)
❑ AMPHETAMINES (PAST)	❑ AMPHETAMINES (PRESENT)
❑ BARBITUATES (PAST)	❑ BARBITUATES (PRESENT)
❑ COCAINE (PAST)	❑ COCAINE (PRESENT)
❑ CRYSTAL METH (PAST)	❑ CRYSTAL METH (PRESENT)
❑ HEROINE (PAST)	❑ HEROINE (PRESENT)
❑ MARIJUANA (PAST)	❑ MARIJUANA (PRESENT)

OCCUPATIONAL ACTIVITIES	
❑ BUSINESS OWNER	❑ COMPUTER/ADMINISTRATIVE
❑ EXECUTIVE/LEGAL	❑ FOOD SERVICES
❑ HEALTHCARE/HOMESERVICES	❑ CONSTRUCTION/LABORER
❑ HOUSHOLD	❑ OTHER:_____

RECREATIONAL ACTIVITIES	
❑ BACKPACKING	❑ BOATING
❑ GOLF	❑ RUNNING
❑ SOCCER	❑ TENNIS
❑ WEIGHT LIFTING	❑ FOOTBALL
❑ BIKING	❑ SKIING
❑ RACQUETBALL	❑ WALKING
❑ SWIMMING	❑ OTHER: _____

WOMEN ONLY	
ARE YOU PREGNANT? ❑NO ❑YES	DUE DATE: _____
IF PREGNANT IN PAST, WERE PREGNANCIES NORMAL? ❑YES ❑NO	
ARE YOU SEEING AN OB-GYN REGULARLY? ❑YES ❑NO	
# OF BIRTHS:	DATE OF LAST EXAM:
PHYSICIAN'S NAME & ADDRESS:	

FAMILY HISTORY (Check appropriate boxes if they affected that person.)

❑ ADOPTED, UNKOWN HISTORY	FATHER	MOTHER	BROTHERS	SISTERS	CHILDREN
ANEMIA					
ARTHRITIS					
BACK / DISC PROBLEMS					
CANCER					
CHOLESTEROL					
CONGENITAL DEFECTS					
DIABETES					
GENETIC DISEASE					
HEADACHES					
HEART TROUBLE					
HIGH BLOOD PRESSURE					
JOINT PROBLEMS					
KIDNEY DISEASE					
MENTAL ILLNESS					
MULTIPLE SCLEROSIS					
OSTEOPOROSIS					
PHSYCHIATRIC					
SCOLIOSIS					
STROKE					
THYROID					
DECEASED					
OTHER: _____					

Name:_____

REVIEW OF SYSTEMS

If you are having any of these symptoms currently (less than 4 weeks) check present or if greater than 4 weeks check past.

CARDIOVASCULAR

	PRESENT	PAST
POOR CIRCULATION		
HIGH BLOOD PRESSURE		
AORTIC ANEURYSM		
HEART DISEASE		
HEART ATTACK		
CHEST PAIN		
HIGH CHOLESTEROL		
PACE MAKER		
JAW PAIN		
IRREGULAR HEARTBEAT		
SWELLING OF LEGS		

GENITOURINARY

	PRESENT	PAST
KIDNEY DISEASE		
LOWER SIDE PAIN		
BURNING URINATION		
FREQUENT URINATION		
BLOOD IN URINE		
KIDNEY STONE		

HEMATOLOGIC/ LYMPHATIC

	PRESENT	PAST
HEPATITIS		
BLOOD CLOTS		
CANCER		
EASY BRUISING		
EASY BLEEDING		
FEVERS/CHILLS/SWEATS		

RESPIRATORY

	PRESENT	PAST
ASTHMA		
TUBERCULOSIS		
SHORTNESS OF BREATH		
EMPHYSEMA		
COLD/FLU		
COUGH/WHEEZING		
BRONCHITIS		
PNEUMONIA		

EARS/ NOSE/ THROAT

	PRESENT	PAST
DIZZINESS		
HEARING LOSS		
SINUS INFECTION		
NOSEBLEED		
SORE THROAT		
DIFFICULTY SWALLOWING		
BLEEDING GUMS		
EAR INFECTION		

EYES

	PRESENT	PAST
GLAUCOMA		
DOUBLE VISION		
BLURRED VISION		

INTEGUMENTARY

	PRESENT	PAST
SKIN ULCERS		
SKIN DISEASE		
ECZEMA		
PSORIASIS		
RASHES		

ALLERGIC/ IMMUNOLOGIC

	PRESENT	PAST
HIVES		
IMMUNE DISORDER		
HIV/AIDS		
ALLERGY SHOTS		
ALLERGY MEDS		
CORTISONE USE		

GASTROINTESTINAL

	PRESENT	PAST
GALLBLADDER PROBLEMS		
BOWEL PROBLEMS		
CONSTIPATION		
LIVER PROBLEMS		
ULCERS		
DIARRHEA		
NAUSEA/VOMITING		
BLOODY STOOLS		
POOR APPETITE		

MUSCULOSKELETAL

	PRESENT	PAST
GOUT		
ARTHRITIS		
JOINT STIFFNESS		
MUSCLE WEAKNESS		
OSTEOPOROSIS		
BROKEN BONES		
JOINTS REPLACED		

ENDOCRINE

	PRESENT	PAST
THYROID DISEASE		
DIABETES		
HAIR LOSS		
MENOPAUSAL		
MENSTRUAL PROBLEMS		

PSYCHIATRIC

	PRESENT	PAST
DEPRESSION		
ANXIETY DISORDER		
UNUSUAL STRESS		

CONSTITUTIONAL

	PRESENT	PAST
WEIGHT LOSS/GAIN		
ENERGY LEVEL PROBLEM		
DIFFICULTY SLEEPING		

NEUROLOGIC

	PRESENT	PAST
STROKE		
SEIZURES		
HEAD INJURY		
BRAIN ANEURYSM		
NUMBNESS		
SEVERE HEADACHES		
PINCHED NERVES		
PARKINSONS DISEASE		
CARPAL TUNNEL		
SPINNING/BALANCE		

HEALTH HISTORY

PLEASE LIST ANY ACCIDENT (AUTO/WORK/OTHER), INJURIES OR FALLS YOU HAD IN THE PAST:

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? ❑YES ❑NO
(PLEASE LIST CURRENT MEDICATIONS AND DOSAGE)

MEDICATION /DOSAGE

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

ARE YOU CURRENTLY TAKING ANY VITAMINS, MINERALS, OR HERBS? ❑YES ❑NO
(PLEASE LIST CURRENT SUPPLEMENTS AND DOSSAGE)

SUPPLEMENT/DOSAGE

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ❑YES ❑NO (LIST ANY KNOWN ALLERGIES THAT YOU HAVE TO MEDICATIONS)

1. _____ 3. _____ 5. _____ 7. _____
2. _____ 4. _____ 6. _____ 8. _____

HAS ANY DOCTOR DIAGNOSED YOU WITH HYPERTENSTION PRESENTLY? ❑ YES ❑ NO
IF YES, WHAT KIND?

HAS ANY DOCTOR DIAGNOSED YOU WITH DIABETES PRESENTLY? ❑ YES ❑ NO IF YES, WHAT KIND? ❑ TYPE 1 ❑ TYPE II
IF YES TO DIABETES, WAS YOUR BLOOD LAB-WORK TEST FOR HEMOGLOBIN A1c > 90%? ❑ YES ❑ NO

HAS ANY DOCTOR DIAGNOSED YOU WITH ANY TYPE OF SIGNIFICANT HEALTH SYNDROME PRESENTLY? ❑ YES ❑ NO ❑ NOT SURE
IF YES, WHAT KIND?

DO YOU CURRENTLY SMOKE TOBACCO OF ANY KIND? ❑ YES ❑ NEVER BEEN A SMOKER ❑ FORMER SMOKER
IF YES, HOW OFTEN DO YOU SMOKE: ❑ CURRENT EVERDAY SMOKER ❑ CURRENT SOMDAY SMOKER
IF YES,: WHAT IS YOUR LEVEL OF INTEREST IN QUITTING SMOKING? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ N/A

Name: _____

RELEASE OF INFORMATION

I _____ give permission to the staff at Spencer Chiropractic Clinic, PC to share any information related to my care, account and services to the following people:

NAME: (LAST, FIRST, MI)		NAME: (LAST, FIRST, MI)	
RELATIONSHIP:		RELATIONSHIP:	
ADDRESS:		ADDRESS:	
CITY:	STATE: ZIP:	CITY:	STATE: ZIP:
PHONE:		PHONE:	

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Ownership of X-ray Films: *It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.*

Correspondence Authorization: *By providing your e-mail you are accepting to receive correspondence regarding your care.*

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximal health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

SIGNATURE:	DATE:
WITNESS SIGNATURE:	DATE:
GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE:	DATE:

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

❑ PATIENT ❑ SPOUSE ❑ PARENT ❑ WORKERS COMP ❑ AUTO INSURANCE ❑ MEDICARE ❑ HEALTH INSURANCE