

BACK TO HEALTH CHIROPRACTIC

Confidential Patient Information Form

Please return completed form to the front desk and have your Drivers License and Insurance Card available.

PERSONAL INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____
Address: _____ Apt#: _____ City: _____ State: _____ Zip: _____
Home phone: _____ Work phone: _____ Cell phone: _____
Email Address: _____
Date of Birth: _____ Gender: Male Female SSN: _____
Marital Status: _____ # of Children: _____
Education (Highest Level): Elementary School High School College Graduate Degree
Primary Care Physician: _____ Phone: _____
Spouse's Name: _____ Date of Birth: _____
Emergency Contact: _____ Phone: _____ Relation: _____

EMPLOYMENT INFORMATION

Employer: _____
Job Description: _____
Address: _____ City: _____ State: _____ Zip: _____

Status: Full Time Part Time

Have you taken time off of work due to this accident? Yes No

If yes, how many days? _____

Are your activities restricted as a result of this accident? Yes No If yes, please explain

Were you driving for your employer when the accident occurred? Yes No

Patient's Name: _____

ACCIDENT INFORMATION

Date of the Accident _____

What type of vehicle were in? Car Truck Sports Utility Vehicle Bus Sports Car
 Van Motorcycle Sedan Coupe Other _____

Vehicle size? Compact Full Size Light Mid-size Mini Subcompact Semi

Your position in the vehicle? Driver Front Right Passenger Front Middle Passenger
 Back Left Passenger Back Middle Passenger Back Right Passenger

In what State did the accident take place. _____

What were the major cross streets? _____

Was the vehicle moving or at a complete stop. _____

How was the vehicle hit. _____

Amount of damage to the vehicle you were in?

Irreparable Extensive Minimal Moderate Undetermined

The other vehicle was a. Car Truck Sports Utility Vehicle Bus Sports Car
 Van Motorcycle Sedan Coupe Other _____

Damage to the other vehicle?

Irreparable Extensive Minimal Moderate Undetermined

Weather conditions? Clear Cloudy Drizzling Foggy Rainy Snowing
 Stormy Sunny

Road conditions?

Damp Dry Dry with Ice Patches Iced Over Snowed Over Wet

Visibility? Fair Good Poor

Time of Day? Dawn Day Dusk Night

Body Position at Impact? Leaning Forward Slouched down in seat Straight
 Turned to the Left Turned to the Right

Direction Body was Thrown? Backward then Forward Forward then Backward
 To the Left To the Right About the Vehicle Outside the Vehicle Under the Vehicle

Patient's Name: _____

Head Position at Impact? Straight Tilted Forward Turned Left Turned Right

Direction Head was Thrown? Back the Forward Forward then Back Side to Side

Position of headrest? High Position Middle Position Low Position Not Installed
In a Position that I don't recall

Were you wearing your seatbelt? Yes No

Did the airbag deploy? Yes No

Did you brace for Impact? Yes No

Your Initial Reaction? Confused Dazed Distressed Dizzy Frightened
Light Headed Nervous Shaken Upset Weak Other _____

Please explain in detail how your accident happened. _____

Where did pain occur after the accident?

Head	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neck	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rib Cage	<input type="checkbox"/> Yes <input type="checkbox"/> No
Right Shoulder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Left Shoulder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest	<input type="checkbox"/> Yes <input type="checkbox"/> No
Right Arm	<input type="checkbox"/> Yes <input type="checkbox"/> No	Left Arm	<input type="checkbox"/> Yes <input type="checkbox"/> No	Upper Back	<input type="checkbox"/> Yes <input type="checkbox"/> No
Right Elbow	<input type="checkbox"/> Yes <input type="checkbox"/> No	Left Elbow	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mid Back	<input type="checkbox"/> Yes <input type="checkbox"/> No
Right Forearm	<input type="checkbox"/> Yes <input type="checkbox"/> No	Left Forearm	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Back	<input type="checkbox"/> Yes <input type="checkbox"/> No
Right Wrist	<input type="checkbox"/> Yes <input type="checkbox"/> No	Left Wrist	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abdomen	<input type="checkbox"/> Yes <input type="checkbox"/> No
Right Hand	<input type="checkbox"/> Yes <input type="checkbox"/> No	Left Hand	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pelvis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Right Buttock	<input type="checkbox"/> Yes <input type="checkbox"/> No	Left Buttock	<input type="checkbox"/> Yes <input type="checkbox"/> No	Right Hip	<input type="checkbox"/> Yes <input type="checkbox"/> No
Right Leg	<input type="checkbox"/> Yes <input type="checkbox"/> No	Left Leg	<input type="checkbox"/> Yes <input type="checkbox"/> No	Left Hip	<input type="checkbox"/> Yes <input type="checkbox"/> No
Right Thigh	<input type="checkbox"/> Yes <input type="checkbox"/> No	Left Thigh	<input type="checkbox"/> Yes <input type="checkbox"/> No	Right Knee	<input type="checkbox"/> Yes <input type="checkbox"/> No
Right Shin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Left Shin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Left Knee	<input type="checkbox"/> Yes <input type="checkbox"/> No
Right Ankle	<input type="checkbox"/> Yes <input type="checkbox"/> No	Left Ankle	<input type="checkbox"/> Yes <input type="checkbox"/> No	Right Foot	<input type="checkbox"/> Yes <input type="checkbox"/> No
Left Foot	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other			

Did you lose consciousness? Yes No

Immediate Destination after the accident? Work School Home Hospital
To a clinic To a doctor's office To this office

Who drove you? Yourself A friend Ambulance A family member
Police Officer Wife Husband Another person

Were you cut or bruised? Yes No If so where. _____

Patient's Name: _____

Date of Hospital / Doctor visit? _____ Name of Hospital / Clinic _____

Were you admitted to the hospital? Yes No Date Discharged _____

Were X-Ray films taken? Yes No If yes, of what area _____

Was a CAT Scan taken? Yes No If yes, of what area _____

Was an MRI performed? Yes No If yes, of what area _____

Treatment Administered? Adjustment Bandaging Casting A collar Hot Pack
 Ice Pack An injection Muscle Relaxant Oral Medication Splinting Supports
 Surgery Sutures Topical Antiseptics

Did they give any recommendations for care? Yes No If yes, please explain. _____

If you have been seen by another healthcare professional for this auto accident, Please ask the front desk for a records release form so that we may obtain them.

NEUROLOGICAL QUESTIONS

Do you now have weakness, numbness or burning sensations in the neck, arm, shoulder, hands, fingers, legs, buttocks or feet? Yes No

Comments: _____

Do you have now a feeling of your hands, arms, legs or feet falling asleep at any time? Yes No

Comments: _____

Do you now have reduced feeling or reduced sensation in your arms, hands, legs, or feet? Yes No

Comments: _____

Do you have now any swelling in your hands, arms, legs or feet? Yes No

Comments: _____

Do you have now a loss of hand grip strength? Yes No

Comments: _____

Do your legs or feet fall asleep? Yes No

Comments: _____

Do your legs or feet get “jumpy feeling”? Yes No

Comments: _____

Do you have Headaches? Yes No

Comments: _____

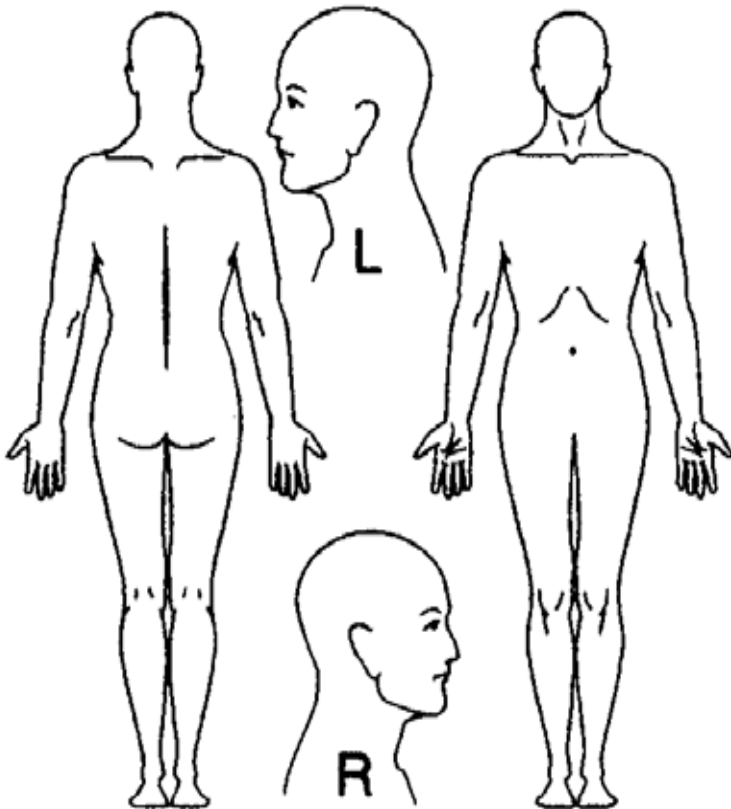
Patient's Name: _____

PAIN SINCE THE ACCIDENT

How Intense Is The Pain (mark an X on the line)

How Frequent Is The Pain?

Area	Low	Moderate	Severe	Constant	Daily	Weekly	Monthly
Head	0-----0			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck	0-----0			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Middle Back	0-----0			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower Back	0-----0			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shoulders	0-----0			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feet	0-----0			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wrists	0-----0			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elbows	0-----0			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	0-----0			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Shade in the areas where you hurt

Use: **XXXXXXXX** for Numbness

Use: for Pins & Needles

Use: **OOOOOO** for Burning

Use: **VVVVVVV** for Dull/Aching

Use: **IIIIIIIIII** for Sharp/Stabbing pain

Since the accident, are your symptoms: Improving Getting worse The same
 Please explain _____

Patient's Name: _____

SOCIAL HISTORY

Do you exercise? Never Rarely Occasionally Regularly Have an active lifestyle
 Regularly prior to this injury

Please explain your exercise program: _____

Do you smoke? Never Previously but don't smoke now Smokes _____ per day
 Chew tobacco

Do you drink alcohol? Never Rarely Occasionally Moderately Excessively
 Drink a few beers on the weekend drank previously but don't drink now

MEDICAL HISTORY

PATIENT HEALTH HISTORY

Please indicate Past (P) or Present (PR) ailments

High Blood Pressure	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Irritability	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	
High Cholesterol	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Excess Perspiration	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	
Diabetes	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Extreme Fatigue	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	
Stomach Pain	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Runny Nose	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	
Heart Murmur	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Sore Throat	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	
Poor Circulation	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Chronic Bronchitis	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	
Chest Congestion	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Chest pain	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	
Depression	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Stomach Ulcers	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	
Stroke	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Nausea / Vomiting	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	
Dizziness	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Frequent Heart Burn	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	
Osteoporosis	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Frequent Constipation	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	
Cancer	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Frequent Diarrhea	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	
Inflammatory Arthritis	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Other _____	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	
Osteoarthritis	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Appendectomy	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Date _____
Asthma	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Back Surgery	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Date _____
Psoriasis	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Female Related Surgery	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Date _____
Ear Infection	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Hip Surgery	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Date _____
Low Blood Pressure	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Knee Surgery	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Date _____
Obesity	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Neck Surgery	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Date _____
ADD or ADHD	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Open Heart Surgery	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Date _____
Bipolar Disorder	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Shoulder Surgery	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Date _____
Prostatitis	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Tonsilectomy	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Date _____
Eye Infection	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Craniotomy	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Date _____
Polio	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Gall Bladder Removed	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Date _____
Insomnia	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Ankle Surgery	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Date _____
Kidney or UTI Infection	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Carpal Tunnel Surgery	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Date _____
					Other _____	<input type="checkbox"/>	P	<input type="checkbox"/>	PR	Date _____

Patient's Name: _____

Family History

High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Inflammatory Arthritic Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unknown Due to Adoption	<input type="checkbox"/> Yes

What medications are you currently taking? _____

Do you have any allergies? _____

Are you being treated currently for any other health problem, serious illness / trauma, chronic or life time condition, or any other ailments? Yes No

If Yes, Please indicate: _____

WOMEN ONLY

Is there any possibility that you may be pregnant? Yes No

If Yes, How far along are you? _____

If No, What birth control method? Abstinence Birth control pills (please list in medication area)
 DEPO Shot Contraceptives Condoms

Date of Last Menstrual Period: _____

Do you have or have had any menstrual disorders? Yes No

If Yes, Please indicate: _____

INSURANCE INFORMATION

Insurance Information from the Person Who Hit You.

Insurance Company Name: _____

Insurance Company Phone Number: _____ Claim # _____

Name of Insured Person Who Hit You: _____

The Name of the Adjuster for the other insurance company? _____

Patient's Name: _____

Your Auto Insurance Information

Your Car Insurance Company Name: _____

Do You Have Med Pay Coverage? No Yes Amount: _____ Claim# _____

Do You Have Uninsured /Underinsured Motorist Coverage? Yes No

The Name of the Adjuster for your insurance? _____

Your Health Insurance Information

Insurance: _____ Type of Insurance Plan: PPO HMO EPO OTHER

Insurance Company Phone Number: _____ ID # _____

Name of Insured: _____ Date of Birth: _____

Address: _____ Apt#: _____ City: _____ State: _____ Zip: _____

Have you retained an attorney? Yes No If yes, name and address of the attorney _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I also understand that providing incorrect information can be dangerous to my health.

Patient / Guarantor's signature

Date

Patient's Name: _____