HICKS CHIROPRACTIC CENTER

POLICY AND PATIENTA DATA

LAST NAME _____ FIRST NAME _____ HOME PHONE _____

ADDRESS _____ CITY, STATE, ZIP _____

CELL PHONE NUMBER: _____ E-MAIL ADDRESS: _____

BIRTHDAY _____ AGE _____ SEX: M or F SS# _____

MARRIED _____ SINGLE _____ WIDOWED _____ DIVORCED _____

EMPLOYER _____ OCCUPATION _____ WORK PHONE _____

SPOUSE'S NAME _____ SPOUSES'S EMPLOYER_____ WORK PHONE _____

WHAT IS YOUR GOAL OF TREATMENT? [ ] LASTING CORRECTIVE CARE or
[ ] TEMPORARY RELIEF OF SYMPTOMS

WHO IS YOUR FAMILY MEDICAL PHYSICIAN OR NURSE PRACTITIONER OR PHYSICIAN ASSISTANT?
_____

WHEN DOCTORS WORK TOGETHER IT BENEFITS YOU. MAY WE HAVE PERMISSION TO UPDATE YOUR MEDICAL DOCTOR REGARDING YOUR CARE AT OUR OFFICE? _____

WHAT TYPES OF HOBBIES/LEISURE ACTIVITIES DO YOU ENJOY? _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

SCREENING QUESTIONS:

1. HAVE YOU EVER/PRESENTLY HAVE CANCER? [ ] YES [ ] NO IF "YES", WHEN AND WHERE?_____
_____

2. ARE YOU LOSING WEIGHT WITHOUT TRYING? (GREATER THAN 10 POUNDS/MONTH?)	[ ] YES [ ] NO
3. DO YOU HAVE A SORE THAT DOES NOT HEAL?	[ ] YES [ ] NO
4. DO YOU HAVE ANY UNUSUAL BLEEDING OR DISCHARGE?	[ ] YES [ ] NO
5. DO YOU HAVE A THICKENING OR LUMP IN THE BREAST OR ELSEWHERE?	[ ] YES [ ] NO
6. DO YOU HAVE INDIGESTON OR DIFFICULTY SWALLOWING?	[ ] YES [ ] NO
7. DO YOU HAVE A CHANGE IN A WART OR MOLE?	[ ] YES [ ] NO

INFORMED CONSENT/RELEASE OF INFORMATION FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis, and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment, or health care, if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if a Chiropractic Physician at Hicks Chiropractic Center accepts me as a patient, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding Chiropractic treatment, will be explained to me upon my request. According to Indiana Access to Health Records statute, (IC 16-4-8 et, seq.) I authorize the release of any documentation from my insurance company to the provider, which determines the payment or limitations of such on submitted claims, including but not limited to a copy of the chiropractic, medical or other reviews, which were done. I waiver the Statute of Limitations regarding my doctor's rights to recover. I authorize Hicks Chiropractic Center to provide any of my other medical providers with any/all information contained in my medical records to coordinate medical treatment.

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT I HAVE READ THE POLICIES
ABOVE AND AGREE TO ABIDE BY THE SAME.

PATIENT'S SIGNATURE _____ DATE _____

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Financial Responsibility

I have requested professional services from **Hicks Chiropractic Center at 501 W. Kieffer Rd., Michigan City, IN 46360** ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient Date

_____ _____

Policyholder/Insured Date

PATIENT INTAKE FORM

Patient Name:_____ Date:_____

1. **Indicate below the area(s) and intensity of your pain/symptom(s)**

AREA	INTENSITY (scale of 1-10; 10 being the worst)
1_____	_____
2_____	_____
3_____	_____
4_____	_____
5_____	_____

2. **How often do you experience your symptoms?**
   - ○ Constantly (76-100% of the time)
   - ○ Occasionally(26-50% of the time)
   - ○ Frequently (51-75% of the time)
   - ○ Intermittently (1-25% of the time)

3. **How would you describe the type of pain?**

○ Sharp	○ Burning	○ Sharp with motion
○ Dull	○ Shooting	○ Shooting with motion
○ Diffuse	○ Stabbing	○ Stabbing with motion
○ Achy	○ Numb	○ Electric like with motion
○ Stiff	○ Tingly	○ Other_____

4. **How are your symptoms changing with time?**
   ○ Getting Worse ○ Staying the Same ○ Getting Better

5. **How much has the problem interfered with your work?**
   ○ Not at all ○ A little bit ○Moderately ○ Quite a bit ○ Extremely

6. **How much has the problem interfered with your social activities?**
   ○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ Extremely

7. **Who else have you seen for your problem?**

○ Chiropractor	○ Neurologist	○ Primary Care Physician
○ ER Physician	○ Orthopedist	○ Other:_____
○ Massage Therapist	○ Physical Therapist	○ No one

8. **How long have you had this problem?**
   _____

9. **How do you think your problem began?**
   _____

10. **Do you consider this problem to be severe?**
    ○ Yes ○ Yes, at times ○ No

11. What aggravates your problem(s)?

○ Always there	○ Neck Movement	○ Sitting
○ Coughing	○ Reaching	○ Standing
○ Sneezing	○ Lifting	○ Walking
○ Straining at the stool	○ Bending	○ Stairs
○ Exercising	○ Twisting	○ Driving
○ Breathing Deeply	○ Sleeping/Lying	○ Other_____

12. What concerns you the most about your problem; what does it prevent you from doing?_____

13. What is your: Height_____ Weight:_____ Age:_____
Occupation_____

14. How would you rate your overall Health?

○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

15. What type of exercise do you do?

○ Strenuous ○ Moderate ○ Light ○ None

16. Indicate if you have any immediate family members with any of the following:

○ Rheumatoid Arthritis	○ Diabetes	○ Lupus
○ Heart Problems	○ Cancer	○ ALS

17. For each of the following conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
○	○ Headaches	○	○ High Blood Pressure	○	○ Diabetes
○	○ Neck Pain	○	○ Heart Attack	○	○ Excessive Thirst
○	○ Upper Back Pain	○	○ Chest Pains	○	○ Frequent Urination
○	○ Mid Back Pain	○	○ Stroke	○	○ Smoking/Tobacco Use
○	○ Low Back Pain	○	○ Angina	○	○ Recreation Drugs
○	○ Shoulder Pain	○	○ Kidney Stones	○	○ Alcohol Dependence
○	○ Elbow/Arm Pain	○	○ Kidney Disorders	○	○ Allergies
○	○ Wrist Pain	○	○ Bladder Infection	○	○ Depression
○	○ Hand Pain	○	○ Painful Urination	○	○ Systemic Lupus
○	○ Hip Pain	○	○ Loss of Bladder Control	○	○ Epilepsy
○	○ Upper Leg Pain	○	○ Prostate Problems	○	○ Eczema/Rash
○	○ Knee Pain	○	○ Abnormal weight loss/gain	○	○ HIV/AIDS
○	○ Ankle/Foot Pain	○	○ Loss of Appetite		
○	○ Jaw Pain	○	○ Abdominal Pain	**For Females Only**	
○	○ Joint Pain/Stiffness	○	○ Ulcer	○	○ Birth control pills
○	○ Arthritis	○	○ Hepatitis	○	○ Hormone Therapy
○	○ Rheumatoid Arthritis	○	○ General Fatigue	○	○ Pregnancy
○	○ Cancer	○	○ Liver/Gallbladder Disorder		
○	○ Tumor	○	○ Muscular Incordination		
○	○ Asthma	○	○ Visual Disturbances		
○	○ Chronic Sinusitis	○	○ Dizziness	○	○Other_____

18. List all prescription medications you are currently taking:

_____

_____

19. List all of the over-the-counter medications/supplements you are currently taking:

_____

20. List all surgical procedures and dates in the past 5-6 years:

_____

_____

21. What activities do you do at work? ○ Not Applicable

○ **Sit:**	○ Most of the day	○ Half the day	○ A little of the day
○ **Stand:**	○ Most of the day	○ Half the day	○ A little of the day
○ **Computer work:**	○ Most of the day	○ Half the day	○ A little of the day
○ **On the phone:**	○ Most of the day	○ Half the day	○ A little of the day

22. What activities/hobbies do you do outside of work?

_____

23. Have you ever been hospitalized in the past 5-6 years? ○ Yes ○ No

If yes, why and dates_____

_____

24. Have you had significant past trauma? ○ Yes ○ No

If yes, explain:_____

_____

25. Anything else pertinent to your visit today?_____

Patient Signature_____ Date_____

Notes:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Noti**c**e of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score

Injury History Form

Patient's name: _____
Today's date: _____
Date of injury: _____

▪What state did the accident occur in? _____
▪What city did the accident occur in? _____
▪What street or intersection were you on when the accident occurred? _____
_____

▪You were:
☐Driver ☐Front seat passenger
☐Rear seat passenger ☐Motorcycle operator
☐Motorcycle passenger ☐Other _____

▪The vehicle you were in:
☐ Subcompact ☐ Compact ☐ Mid Size ☐ Full Size
☐ Truck ☐ SUV ☐ Mini Van ☐ Van
☐ Other: _____

▪Your estimated speed at moment of crash: ____mph
☐Stopped ☐Slowing ☐Accelerating

▪Type of vehicle(s) that impacted your vehicle:
☐ Subcompact ☐ Compact ☐ Mid Size ☐ Full Size
☐ Truck ☐ SUV ☐ Mini Van ☐ Van
☐ Other: _____

▪ Number of Vehicles involved? _____
▪ Estimated speed of other vehicle: _____mph
☐Slowing Down ☐Gaining Speed
☐Stopped ☐Moving at steady Speed

▪Head restraints:
☐None ☐Movable/Adjustable ☐ Non movable
☐Don't know

▪If adjustable, how was headrest positioned on head?
☐Headrest at top of head ☐ Headrest at middle of head
☐ Headrest at back of neck ☐ Headrest level of shoulder

▪Lap belt: ☐Wearing ☐Not wearing ☐None
☐Don't know

▪Shoulder belt: ☐Wearing ☐Not wearing ☐None
☐Don't know

▪Body position at time of impact:
☐Straight ☐Forward lean ☐Turned(R or L)
☐Other_____

▪Head position at time of impact:
☐Forward ☐Turned Left ☐Turned Right
☐Looking Up ☐Looking Down

▪Hands:
☐One on wheel ☐Two on wheel ☐N/A

▪Aware of impending crash? ☐Yes ☐No
▪Did you brace for the crash? ☐Yes ☐No

▪Crash description: _____
_____
_____
_____
_____

Primary impact to your vehicle:
☐Rear ended ☐Your vehicle rear-ended another vehicle
☐Hit on drivers side ☐Hit on passengers side
☐Other (explain): _____
_____
_____

▪During and after the crash what happened to your vehicle? (check all that apply)
☐kept going straight ☐spun around
☐was hit by another vehicle ☐hit a tree
☐kept going straight hitting a car in front
☐spun around and hit a stationary object
☐ Hit guard rail ☐Vehicle rolled over
☐ Vehicle went into ditch

▪Did your face hit anything? ☐ N/A
☐ Windshield ☐ Steering Wheel ☐ Side Door
☐ Dashboard ☐ Ceiling ☐ Car Frame
☐ Another Passenger ☐ Seat ☐ Side Window
☐ Other: _____

▪Did your neck hit anything? ☐ N/A
☐ Windshield ☐ Steering Wheel ☐ Side Door
☐ Dashboard ☐ Ceiling ☐ Car Frame
☐ Another Passenger ☐ Seat ☐ Side Window
☐ Other: _____

▪Did your chest hit anything? ☐ N/A
☐ Windshield ☐ Steering Wheel ☐ Side Door
☐ Dashboard ☐ Ceiling ☐ Car Frame
☐ Another Passenger ☐ Seat ☐ Side Window
☐ Other: _____

▪Did your knees hit anything? ☐ N/A
☐ Windshield ☐ Steering Wheel ☐ Side Door
☐ Dashboard ☐ Ceiling ☐ Car Frame
☐ Another Passenger ☐ Seat ☐ Side Window
☐ Other: _____

▪Did you slide out of your seatbelt during the accident? ☐Yes ☐No

▪What was damaged in/on your vehicle? (check all that apply)
☐Windshield ☐Rear Window ☐Trunk
☐Steering Wheel ☐Mirror ☐Front Lt.Door
☐Dashboard ☐Knee Bolster ☐Front Rt. Door
☐Seat Frame ☐Rear Bumper ☐Back Lt. Door
☐Side Window ☐ Front Bumper ☐Back Rt. Door
☐Completely totaled ☐ Other: _____

Injury History Form

▪Did you lose consciousness? ☐Yes ☐No
If yes, for how long? _____

▪Estimated damage to your vehicle (Cost if known): $_____Dollars
☐None ☐Minimal ☐Moderate ☐Major

▪Where did you go after the crash?
☐Home ☐Work ☐ Other: _____
☐Hospital Name: _____
Mode of transportation:☐Ambulance ☐Drove yourself
☐Other_____
☐Family Doctor or Convenience Clinic (circle one if applies)
Name: _____

Emergency department (If applies): ☐N/A

▪Radiographs: ☐Yes ☐No
☐X-rays ☐MRIs ☐Special Imaging
Body parts imaged: _____
Results: _____
_____

▪Cervical Collar? ☐Yes ☐No
▪Back Brace? ☐Yes ☐No
▪Medications Prescribed: ☐ N/A
☐ Pain Medication ☐ Muscle Relaxants
☐ Anti-Inflammatory ☐ Pain Injection
▪Were you admitted overnight? ☐Yes ☐No
▪Any stitches or cuts?: ☐Yes ☐No _____

▪ Did your head hit anything? ☐ N/A
☐ Windshield ☐ Steering Wheel ☐ Side Door
☐ Dashboard ☐ Ceiling ☐ Car Frame
☐ Another Passenger ☐ Seat ☐ Side Window
☐ Other: _____

▪ Did your shoulders hit anything? ☐ N/A
☐ Windshield ☐ Steering Wheel ☐ Side Door
☐ Dashboard ☐ Ceiling ☐ Car Frame
☐ Another Passenger ☐ Seat ☐ Side Window
☐ Other: _____

▪ Did your hips hit anything? ☐ N/A
☐ Windshield ☐ Steering Wheel ☐ Side Door
☐ Dashboard ☐ Ceiling ☐ Car Frame
☐ Another Passenger ☐ Seat ☐ Side Window
☐ Other: _____

▪ Did your feet hit anything? ☐ N/A
☐ Windshield ☐ Steering Wheel ☐ Side Door
☐ Dashboard ☐ Ceiling ☐ Car Frame
☐ Another Passenger ☐ Seat ☐ Side Window
☐ Other: _____

▪Employment at time of crash:
_____
☐Unemployed, Due to crash? ☐Yes ☐No
▪Type of work: ☐Office/clerical ☐Light labor
☐Moderate labor ☐Heavy labor
▪Did you miss work due to your injury?
☐Yes ☐No
Dates missed: From _____to _____
▪Reason for today's visit:
☐Persistent complaint ☐Worsening of symptoms
☐Other
▪Any prior treatment or injuries to the affected areas before this crash?:
☐Yes, explain below ☐No
_____
_____
_____

Injury History General

▪Time of day:
☐Daylight ☐Dawn ☐Dusk ☐Dark
▪Road conditions:
☐Dry ☐Damp ☐Wet ☐Snow ☐Ice
☐Other _____
▪Was the seat back broken? ☐Yes ☐No
▪Did the air bag deploy? ☐Yes ☐No
If yes, were you struck? ☐Yes ☐No
▪Brake applied? ☐Yes ☐No

During the Crash

▪Wearing a hat or glasses? ☐Yes ☐No
If yes, still on after crash? ☐Yes ☐No
▪If there were lacerations (cuts), where were they?
☐Head ☐Neck ☐Abdomen
☐Upper/Mid back ☐Lower back ☐Pelvis
☐Chest/Rib cage
☐Shoulders (R, L) ☐Arms (R, L) ☐Elbows (R, L)
☐Forearms (R, L) ☐Wrists (R, L) ☐Hands (R, L)
☐Buttocks (R, L) ☐Hips (R, L) ☐Thighs (R, L)
☐Knees (R, L) ☐Legs (R, L) ☐Ankles (R, L)
☐Feet (R, L) ☐Other _____
▪Did you receive emergency care at the accident site? ☐Yes ☐No
If yes, what type of care?
☐Bandages ☐Splints ☐Brace ☐Neck collar
☐Other _____
☐None ☐Minimal ☐Moderate ☐Major
▪Were the police on-scene? ☐Yes ☐No
If yes, was a report made? ☐Yes ☐No

Injury History Form

After the crash

▪Symptoms you have experienced (check all that apply):

☐Headache	☐Dizziness	☐Nausea
☐Neck pain	☐Back pain	☐Blurred vision
☐Double vision	☐Reduced vision	☐Chest pain
☐Palpitations	☐Impaired hearing	☐Constipation
☐Diarrhea	☐Vomiting	☐Anxiety
☐Tension	☐Frequent urination	☐Depression
☐Mood swings	☐Painful urination	☐Nervousness
☐Poor memory	☐Convulsions	☐Fatigue
☐Restlessness	☐Loss of balance	☐Insomnia
☐Weakness	☐Light sensitivity	☐Weight gain
☐Weight loss	☐Reduced Appetite	☐Ringing in ears
☐Difficulty breathing	☐Confusion/disorientation	
☐Inability to hold urine		
☐Numbness/Tingling		

If yes, where? _____

▪When did symptoms first appear?

☐Immediately

☐After _____hour(s)after the accident, please clarify which symptoms _____

▪Are you restricted in any of the following areas as a result of the accident?

☐Daily living ☐Occupational/Work

☐Recreational activities ☐Other _____

▪Did you self-treat your symptoms?

☐Yes ☐No

If yes, please describe: ☐Ice ☐Heat ☐Bed rest

☐Over-the-counter medication

☐Other _____

Treatment history since the accident

1. Medical Doctor seen:_____
Specialty:_____
Dates Treatment given: _____
Currently treating? ☐Yes ☐No
Special tests done: _____
Referred to: _____ ☐N/A
Did treatment help? ☐Yes ☐No
Notes: _____
_____

2. Medical Doctor seen:_____
Specialty:_____
Dates Treatment given:_____
Currently treating? ☐Yes ☐No
Special tests done: _____
Referred to: _____ ☐N/A
Did treatment help? ☐Yes ☐No
Notes: _____

3. Medical Doctor seen:_____
Specialty:_____
Dates Treatment given:_____
Currently treating? ☐Yes ☐No
Special tests done: _____
Referred to: _____ ☐N/A
Did treatment help? ☐Yes ☐No
Notes: _____
_____

4. Physical Therapy:_____
Performed where:_____
Dates of treatment:_____
Treatment given: _____
Currently treating? ☐Yes ☐No
Special tests done: _____
Referred to: _____ ☐N/A
Did treatment help? ☐Yes ☐No
Notes: _____
_____

5. Chiropractic Doctor seen:_____
Dates Treatment given:_____
Currently treating? ☐Yes ☐No
Special tests done: _____
Referred to: _____ ☐N/A
Did treatment help? ☐Yes ☐No
Notes: _____
_____

Any other information regarding this injury?

☐No
☐Yes: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____