CASE HISTORY
ACCIDENT

Please Print
Patient Name_____ Today's Date_____
First MI Last

Address_____ City_____ State_____ Zip_____

SSN_____ Birth date_____ Age_____ ☐ Male ☐ Female

Home phone#_____ Work phone #_____ Cel#_____

Check appropriate box: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other_____

Employer_____ Occupation_____

Spouse's name_____ His/her employer_____

Referred by: ☐ Yellow Pages ☐ Insurance ☐ Other_____

Have you been to a chiropractor before? ☐ No ☐ Yes, when?_____

Person to contact in case of emergency_____ Phone_____

Family History – has any blood relative had any of the following: (check if yes, leave blank if uncertain)

	Relationship		Relationship
☐ Back problems	_____	☐ Heart Disease	_____
☐ Cancer	_____	☐ Migraine Headaches	_____
☐ Diabetes	_____	☐ Stroke	_____
☐ Epilepsy	_____	☐ Other	_____

Do you smoke? ☐ Yes ☐ No How Much?_____
For women only: Are you pregnant? ☐ Yes ☐ No

Check the following conditions you have had.

☐ AIDS/HIV	☐ Epilepsy	☐ Multiple Sclerosis	☐ Rheumatoid Arthritis
☐ Anemia	☐ Fractures	☐ Osteoporosis	☐ Appendicitis
☐ Gout	☐ Pacemaker	☐ Stroke	☐ Arthritis
☐ Heart Disease	☐ Parkinson's Disease	☐ Tumors, Growths	☐ Back Trouble
☐ Hepatitis	☐ Pinched Nerve	☐ Cancer	☐ Hernia
☐ Polio	☐ Chicken Pox	☐ Herniated Disc	☐ Prostrate Trouble
☐ Diabetes	☐ Migraine Headache	☐ Prosthesis	☐ Other_____

Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or health practioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services on my behalf or my dependents.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____
Signature Date

Workers Compensation Questionnaire

Name:_____ Today's date:_____

Please explain in detail how your accident happened: _____

_____

_____

Date & Time of Accident _____ ☐ a.m. ☐ p.m.
Where did the accident occur: (if other than employer's address) _____
Was your accident directly related to your work? ☐ Yes ☐ No
Did you report your accident to your employer? ☐ Yes ☐ No
Has treatment for this injury been authorized? ☐ Yes ☐ No
Did you return to work? ☐ Yes ☐ No If so, date returned to work _____
Are your work activites restricted as a result of this accident? ☐ Yes ☐ No
Did you consult any other doctor? ☐ Yes ☐ No
If so, give doctor's name: _____ ☐ D.C. ☐ M.D. ☐ D.O. ☐ D.D.S.
Describe any treatment you received: _____
Have you ever injured this area before: ☐ Yes ☐ No If yes, when? _____

Check symptoms you have noticed since the accident:

☐ Headache	☐ Dizziness	☐ Nausea	☐ Pins & Needles in Arms
☐ Memory Loss	☐ Loss of Balance	☐ Fever	☐ Numbness in Fingers
☐ Blurred Vision	☐ Light Bothers Eyes	☐ Hands Cold	☐ Upper Back Pain
☐ Buzzing in Ears	☐ Head Seems too Heavy	☐ Feet Cold	☐ Upper Back Stiffness
☐ Ears Ringing	☐ Loss of Smell	☐ Jaw Problems	☐ Low Back Pain
☐ Fainting	☐ Loss of Taste	☐ Neck Pain	☐ Leg Pain
☐ Face Flushed	☐ Shortness of Breath	☐ Neck Stiffness	☐ Pins & Needles in Legs
☐ Nervousness	☐ Chest Pain	☐ Arm/Shoulder Pain	☐ Numbness in Toes

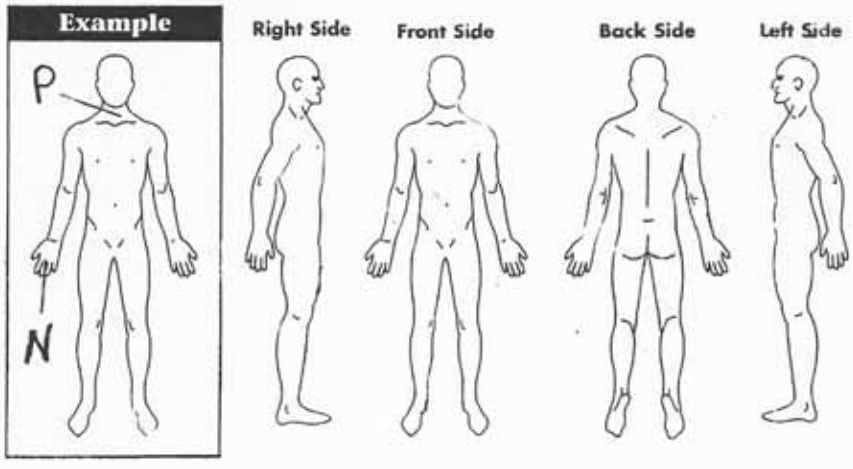
Since this injury are you symptoms: ☐ improving ☐ getting worse ☐ constant ☐ same ☐ comes and goes

List major complaints and rate the intensity of the pain on a scale of 1 to 10.

1. Primary complaint:_____ 1 2 3 4 5 6 7 8 9 10
2. Secondary complaint:_____ 1 2 3 4 5 6 7 8 9 10
3. Other complaint:_____ 1 2 3 4 5 6 7 8 9 10

Please mark on the drawings below, the area(s) and type of pain/sensation that you are feeling.

Numbness.....N
Pain.....P
Tingling.....T
Ache.....A
Stiffness.....S



_____
Signature