# Patient Information and History

Name_____Home/Cell Phone_____
Address_____
Birthdate_____Male___Female___Patient SS#_____
O Married O Single O Divorce HEIGHT_____ WEIGHT_____
Occupation_____Employer_____
Employer Address_____Employer Phone_____

**In Case Of Emergency:**

Contact:_____Relationship:_____
Home Phone_____ Work Phone _____

Responsible Party's Auto Insurance Company Name_____
Insurance Company Phone ( )_____
Claim # _____Policy _____Adjuster_____
Your Auto Insurance Company _____
Phone_____
Claim #_____ Policy _____Adjuster_____

**Attorney**

Name _____Phone ( )_____
Address_____City_____State_____Zip_____

**NATURE OF ACCIDENT:**

1. Date of Accident_____Time of Day_____
2. Were you: ( ) Driver ( ) Passenger ( ) Front seat ( ) Back Seat
3. ( ) Slip and Fall ( ) Hit As Pedestrian Other_____
4. Number of people in your vehicle:_____ Were you wearing a seatbelt Y( ) N( )
5. What direction was you headed? ( ) North ( ) East ( ) South ( ) West
6. On (name of street)_____
7. What direction was the other vehicle headed? ( ) North ( ) East ( )South ( ) West
8. On ( name of street)_____
9. Was impact from: ( ) Front ( ) Behind ( )Right side ( ) Left side
   Other_____
10. Approximate speed of your car? _____mph Other car_____mph
11. Were you unconscious? ( ) Yes ( ) No If yes, for how long?_____
12. Did the police come to the accident site: ( )Yes ( ) No
13. Were there any witnesses ( )Yes ( ) No
14. In your own words. please describe accident_____

14.Did you have any Physical Complaints/Accidents/Injuries BEFORE THE ACCIDENT:

15.Please describe how you felt:_____

a. During the accident: _____
b. Immediately after the accident: _____
c. Later that day: _____
d. The next day: _____

16. Where were you taken after the accident ?_____
17. Name of the Hospital and/or Clinic, If ANY?_____
18. What type of treatment did you receive?
( ) X-ray ( ) Medications_____

19. What are the present complaints and symptoms_____

| | YES | NO |
|---|---|---|
| SMOKE | ____ | ____ |
| CANCER | ____ | ____ |
| HIGH BLOOD PRESSURE | ____ | ____ |
| STROKE | ____ | ____ |
| HEART ATTACK | ____ | ____ |
| BREAST LUMP | ____ | ____ |
| DIZZINESS | ____ | ____ |
| HEADACHES | ____ | ____ |
| EPILEPSY | ____ | ____ |
| ANEMIA | ____ | ____ |
| DIABETES | ____ | ____ |
| KIDNEY PROBLEM | ____ | ____ |
| LIVER PROBLEM | ____ | ____ |
| GALL BLADDER PROBLEM | ____ | ____ |
| PROSTATE PROBLEM | ____ | ____ |
| DIGESTIVE PROBLEM | ____ | ____ |
| INTESTINAL PROBLEM | ____ | ____ |
| CHANGE IN BOWEL HABIT | ____ | ____ |
| HIV (AIDS) | ____ | ____ |

DATE:_____ SIGNATURE_____

# CHECK SYMPTOMS YOU NOTICED SINCE ACCIDENT:

## HEAD

- ❑ HEADACHE
- ❑ BACK OF HEAD
- ❑ FOREHEAD
- ❑ TEMPLES
- ❑ MIGRANE
- ❑ HEAD FEELS HEAVY
- ❑ LOSS OF MEMORY
- ❑ LIGHT-HEADEDNESS
- ❑ FAINTING
- ❑ LIGHT BOTHERS EYES
- ❑ LOSS OF SMELL
- ❑ LOSS OF TASTE
- ❑ LOSS OF BALANCE
- ❑ DIZZINESS
- ❑ LOSS OF HEARING
- ❑ PAIN IN EARS
- ❑ RINGING IN EARS
- ❑ BUZZING IN EARS

## ❑ NECK:

- ❑ PAIN IN NECK
- ❑ PAIN IN NECK WITH MOVEMENT
- ❑ PINCHED NERVE IN NECK
- ❑ NECK FEELS OUT OF PLACE
- ❑ PINCHED NERVE IN NECK
- ❑ STIFF NECK
- ❑ MUSCLE SPASM IN NECK
- ❑ GRINDING SOUND IN NECK
- ❑ GRATING SOUNDS IN NECK
- ❑ POPPING SOUND IN NECK
- ❑ ARTHRITIS IN NECK

## SHOULDERS:

- ❑ PAIN IN SHOULDER JOINT((R-L)
- ❑ PAIN ACROSS SHOULDERS
- ❑ BURSITIS (R-L)
- ❑ ARTHRITIS (R-L)
- ❑ CAN'T RAISE ARMS ABOVE SHOULDER LEVEL
- ❑ OVER HEAD
- ❑ TENSION IN SHOULDERS
- ❑ PINCHED NERVE IN SHOULDER
- ❑ MUSCLE SPASMS IN SHOULDER

## ARMS AND HANDS:

- ❑ PAIN IN UPPER ARM
- ❑ PAIN IN FOREARM
- ❑ PAIN IN HANDS
- ❑ PAIN IN FINGERS
- ❑ PINCHED NERVE IN ARM
- ❑ PINCHED NERVE IN FINGERS
- ❑ SENSATION OF PINS AND NEEDLES IN ARMS
- ❑ SENSATION OF PINS AND NEEDLES IN FINGERS
- ❑ FINGER GO TO SLEEP
- ❑ HANDS COLD
- ❑ SWOLLEN JOINTS IN FINGERS
- ❑ SORE JOINTS IN FINGERS
- ❑ ARTHRITIS IN FINGERS
- ❑ LOSS OF GRIP STRENGTH

## MID-BACK

- ❑ MID-BACK PAIN
- ❑ PAIN BETWEEN SHOULDER BLADES
- ❑ SHARP STABBING PAIN MID-BACK
- ❑ MUSCLE SPASM

## CHEST

- ❑ CHEST PAIN
- ❑ SHORTNESS OF BREATH
- ❑ PAIN AROUND RIBS

## ABDOMEN:

- ❑ NERVOUS STOMACH
- ❑ NAUSEA
- ❑ GAS
- ❑ CONSTIPATION
- ❑ DIARRHEA

## WOMEN ONLY:

- ❑ MENSTRUAL PAIN
- ❑ CRAMPING
- ❑ IRREGULARITY

## LOW BACK:

- ❑ LOW BACK PAIN
- ❑ LOW BACK PAIN IS WORSE WHEN
- ❑ WORKING
- ❑ STOOPING
- ❑ STANDING
- ❑ SITTING
- ❑ BENDING
- ❑ COUGHING
- ❑ PINCHED NERVE IN LOW BACK
- ❑ SLIPPED DISC
- ❑ LOW BACK FEELS OUT OF PLACE
- ❑ MUSCLE SPASMS
- ❑ ARTHRITIS

## HIPS, LEGS, FEET:

- ❑ PAIN IN BUTTOCKS (R-L)
- ❑ PAIN IN HIP JOINT (R-L)
- ❑ PAIN DOWN LEG (R-L)
- ❑ LEG CRAMPS (R-L)
- ❑ PINS AND NEEDLES IN LEGS
- ❑ NUMBNESS OF LEG (R-L)
- ❑ NUMBNES OF FEET (R-L)
- ❑ NUMBNESS OF TOES (R-L)
- ❑ FEET FEEL COLD (R-L)
- ❑ CRAMPS IN FEET (R-L)
- ❑ SWOLLEN ANKLES (R-L)
- ❑ SWOLLEN FEET (R-L)
- ❑ PAINFULL JOINTS IN TOES

## GENERAL

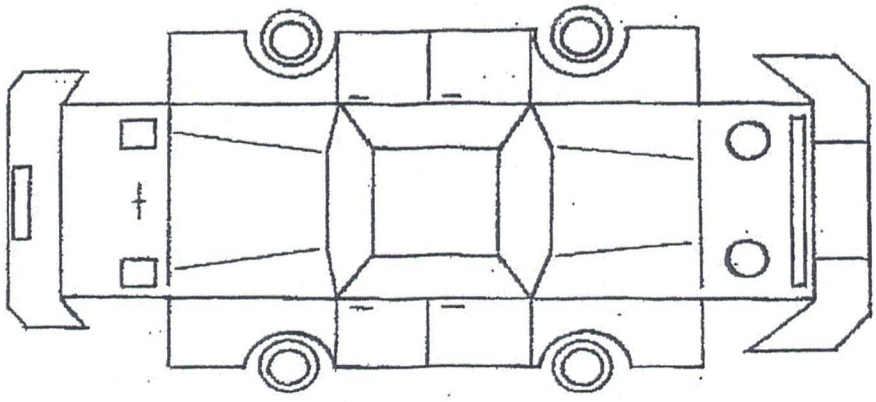
- ❑ NERVOUSNESS
- ❑ IRRITABLE
- ❑ DEPRESSED
- ❑ FATIGUED
- ❑ GENERALLY FEEL RUN DOWN
- ❑ LOSS OF SLEEP
- ❑ LOSS OF WEIGHT

ADVANCED CHIROPACTIC REHAB, INC

PLACE (X) IN THE AREA WHERE
you were seated

PLACE AN (+) WHERE
THE CAR WAS HIT.

BACK OF CAR



FRONT

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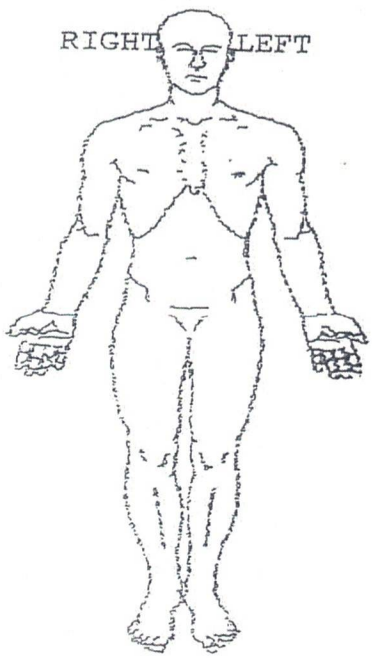
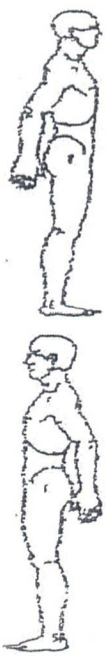
PLACE AN X IN THE AREA WERE YOU HAVE THE MOST PAIN.

FRONT VIEW




SIDE VIEW



BACK VIEW