

Case No. _____
 Last Name _____
 Address _____
 City _____ State _____ Zip _____
 Occupation _____
 Employer _____
 Children(s) Name/Age _____
 Health Insurance _____
 Email Address _____

First Name _____ Middle _____
 SS# _____ Birthdate _____ Age _____
 Home # _____ Work # _____
 Cell # _____
 Spouse _____
 Spouse's Occupation _____
 Employer _____

Please list your major complaints.

- 1) _____
- 2) _____
- 3) _____

How long?	Is it getting better/ worse/ or same?	Constant or comes & goes
_____	_____	_____
_____	_____	_____
_____	_____	_____

Did your injury occur while at work or from a motor vehicle accident? _____

Please put marks on the drawings below to show where you are feeling pain.

SHARP	XX
	XX
BURNING	++
	++
DULL PAIN	✓✓
	✓✓
NUMB	OO
	OO
PINS & NEEDLES	***

Check if you are experiencing any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Sore Muscles | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Shoulder Problems | <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Numbness-Arms | <input type="checkbox"/> Muscle Cramps | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Pain between Shoulders | <input type="checkbox"/> Weak Muscles | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Low Back Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Poor Digestion |
| <input type="checkbox"/> Numbness-Legs | <input type="checkbox"/> Fainting | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Loss of Feeling | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Stiff Joints | <input type="checkbox"/> Depression | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Painful Joints | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Kidney Infection |
| <input type="checkbox"/> Restricts Daily Activities | <input type="checkbox"/> Ear Pain/Noises | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Restricts Regular Exercises | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Frequent Colds |
| <input type="checkbox"/> Tiredness/Fatigue | <input type="checkbox"/> High/Low | |

•Did you receive treatment? Yes No

If yes, what treatment was provided? _____

•Name of family physician: _____

•Have you ever been hospitalized? Yes No

Name of Doctor _____ Date _____

•Have you ever had Chiropractic care before? Yes No

Name of Doctor _____ Date _____

•Last time you had spinal X-rays or other X-rays _____

•Medications you now take: _____

Please list accidents/injuries/surgeries by date, i.e. broken bones, back injury, neck injury.

Any chance of pregnancy? _____

How did you hear about our office? _____

I understand and agree that accident insurance policies are an agreement between insurance carrier and myself. I understand that HealthWise Chiropractic P.C. will prepare any necessary reports or forms to assist me in making collections from the insurance company. Any amount authorized to be paid directly to HealthWise Chiropractic P.C. will be credited directly to my account upon receipt. However, I clearly understand that I am personally responsible for payment of my charges.

 Patient Signature Date: _____

In case of emergency, please notify: _____ Phone: _____



Personal Injury Patient History

Name _____ Date _____
Employer's Name _____
Employer's Address _____
Employer's Phone Number _____ City _____
State _____ Zip Code _____
Occupation _____ Job Description _____
Date of Injury _____ Time of Injury _____ Date Last Worked _____
To Whom Did You Report This Injury: _____
Date Injury Reported: _____

ACCIDENT INFORMATION

How did the accident/injury happen (lifting, twisting, fall, etc.)? _____

When did your pain begin? _____

Where in your body did you first feel pain? _____

Was the pain intense at first, or did you feel pain that gradually worsened? (Be Specific.)

Describe the environmental conditions which may have contributed to your present injury: (darkness, faulty equipment, slippery floor)? _____

Were you hospitalized as a result of this accident? ___ Yes ___ No

Were you treated by doctor/hospital/clinic? _____

DOCTOR INFORMATION

Doctor's Name: _____ Date of first visit: _____

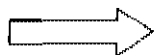
Were you examined? ___ Yes ___ No Were X-Rays taken? ___ Yes ___ No

Did you receive treatment? ___ Yes ___ No

If yes, what treatment was provided? _____

What benefits did you gain from treatment? _____

Date of last treatment? _____



Have you lost any time from work as a result of this new injury? ___ Yes ___ No

If yes, give dates of time lost: _____

Have you gone back to work? ___ Yes ___ No

If yes, what status of work? ___ Modified ___ Regular

When did you return to work? _____

Please list any restrictions: _____

Do you find any activities performed at home to be painful or difficult? ___ Yes ___ No

If yes, please list specific activities that you are unable to do: _____

What activities/exercises could you do before the work-related that you no longer do because of pain or loss of function? _____

Did you have any physical complaints just before this accident? ___ Yes ___ No

If yes, please describe any physical complaints just before the accident? _____

COMPLAINTS PRIOR TO INJURY

Have you *EVER* had any *PRIOR* injuries, accidents, diseases or treatment to the area of your body now affected? ___ Yes ___ No

If yes, please state what part of your body was *PREVIOUSLY* injured: _____

Describe the injury: _____

Date injured: _____

Did you receive care for this injury? ___ Yes ___ No

If yes, who treated you? _____

When was the last time (date) you felt pain or problems from that injury? _____

DO YOU HAVE AN ATTORNEY ON THIS CASE? ___ Yes ___ No

If yes, Attorney Name: _____ Phone: _____

Address: _____ City: _____ State: ___ Zip: _____

Patient Signature

Date



Workers' Compensation Patient History

Name _____ Date _____
Employer's Name _____
Employer's Address _____
Employer's Phone Number _____ City _____
State _____ Zip Code _____
Occupation _____ Job Description _____
Date of Injury _____ Time of Injury _____ Date Last Worked _____
To Whom Did You Report This Injury: _____
Date Injury Reported: _____

ACCIDENT INFORMATION

How did the accident/injury happen (lifting, twisting, fall, etc.)? _____

When did your pain begin? _____

Where in your body did you first feel pain? _____

Was the pain intense at first, or did you feel pain that gradually worsened? (Be Specific.)

Describe the environmental conditions which may have contributed to your present injury: (darkness, faulty equipment, slippery floor)? _____

Were you hospitalized as a result of this accident? ___ Yes ___ No

Were you treated by doctor/hospital/clinic? _____

DOCTOR INFORMATION

Doctor's Name: _____ Date of first visit: _____
Were you examined? ___ Yes ___ No Were X-Rays taken? ___ Yes ___ No
Did you receive treatment? ___ Yes ___ No

If yes, what treatment was provided? _____
What benefits did you gain from treatment? _____
Date of last treatment? _____



Have you lost any time from work as a result of this new injury? ___ Yes ___ No
If yes, give dates of time lost: _____

Have you gone back to work? ___ Yes ___ No
If yes, what status of work? ___ Modified ___ Regular
When did you return to work? _____
Please list any restrictions: _____
Do you find any activities performed at home to be painful or difficult? ___ Yes ___ No
If yes, please list specific activities that you are unable to do: _____

What activities/exercises could you do before the work-related that you no longer do because of pain or loss of function? _____

Did you have any physical complaints just before this accident? ___ Yes ___ No
If yes, please describe any physical complaints just before the accident? _____

COMPLAINTS PRIOR TO INJURY

Have you *EVER* had any *PRIOR* injuries, accidents, diseases or treatment to the area of your body now affected? ___ Yes ___ No
If yes, please state what part of your body was *PREVIOUSLY* injured: _____

Describe the injury: _____
Date injured: _____
Did you receive care for this injury? ___ Yes ___ No
If yes, who treated you? _____
When was the last time (date) you felt pain or problems from that injury? _____

DO YOU HAVE AN ATTORNEY ON THIS CASE? ___ Yes ___ No

If yes, Attorney Name: _____ Phone: _____
Address: _____ City: _____ State: ___ Zip: _____

Patient Signature

Date



AUTOMOBILE ACCIDENT HISTORY

Name: _____ Today's Date: _____
 Date of Accident: _____ Time of Accident: _____ a.m./p.m.
 City of Accident: _____ Street of Accident: _____

Road conditions at the time of accident: **Wet Dry Icy Other**
 Did the police come to the scene? **Yes No** Is there a police report? **Yes No**
 Did you go to the hospital? _____
 If yes, what is the name of the hospital? _____
 How did you get to the hospital? _____
 What parts of your body were x-rayed at the hospital? _____
 How long did you stay at the hospital? _____
 What bleeding cuts did you sustain in the accident? _____
 What bruises did you sustain in the accident? _____
 Where were **YOU** seated in the vehicle? _____
 Were you aware of the approaching collision prior to impact, or did impact catch you by surprise? **Aware Surprise**
 Did you loose consciousness (black out) upon impact? **Yes No** How long? _____
 Did you experience a flash of light or explosion in your head? **Yes No**
 Did you become: **Confused Disoriented Light Headed Dizzy**
Nauseated Blurred Vision Ringing/Buzzing In Ears
 From the accident? (please circle all that apply)

If you still have any symptoms, which ones? _____
 Are you currently suffering from any of the following? (please circle)

- | | |
|----------------------------------|-------------------------------------|
| Restlessness | Irritable |
| Difficulty concentrating | Difficulty with memory |
| Sleeplessness | Forgetfulness |
| Reduced Tolerance to Heat | Reduced Tolerance to Alcohol |

How far is the top of the headrest or seat back from the top of your head? (approx.) _____ inches Above or Below

Were you wearing you seatbelt? **Yes No**
 If yes, was it a lap belt _____ shoulder lap belt _____

List the **Year** _____ **Make** _____ **Model** _____ of vehicle you were in.

Was the vehicle stopped at the time of impact? _____
 If yes, was the driver's foot also on the brake? _____
 In no, then estimate the speed of the vehicle you were in: _____ mph.

If your vehicle was moving at the time of impact, was it:

Slowing down? Yes No

Gaining speed? Yes No

Traveling at a steady rate of speed? Yes No

What part of the vehicle did the following body parts hit?

Head _____

Chest _____

Right/left shoulder _____

Right/left arm _____

Right/left hip _____

Right/left leg _____

Right/left knee _____

Other _____

Did you suffer any injury or bruises as a result of your seatbelt? Yes No

If yes, please describe _____

What is the estimated cost/damage to the vehicle you were in? \$ _____

Which of the following car parts broke during the accident? (please circle all that apply)

Windshield

Front Seat Back

Right/Left Side Window

Dashboard

Steering Wheel

Other _____

Was the trunk of your body pointing straight forward at the time of impact? Yes No

If no, how was it turned? _____

Was your head pointing straight forward at the time of impact?

If no, which direction was it turned and by how much? _____

What was the Year _____ Make _____ Model _____ of the

other car?

Was other vehicle moving at the time of collision? Yes No

If yes, what was the approximate speed? _____ mph

If the other vehicle was moving at the time of collision, was it: (please circle)

Slowing down

Gaining Speed

Traveling at a Steady Speed

Please describe to the best of your knowledge, what happened during this accident:

Have you seen any other health care providers for injuries related to this accident?

Yes No

If yes, who _____ Results: Good Fair Poor