NEW PATIENT INFORMATION

For Office use Only
Patient #

Patient's First Name_______________ Middle__________ Last________________ Date _____________

Address __________________________________ City ____________________ Zip Code ___________

Home Phone _______________________________ Cell Phone_________________________________

E-mail ____ Social Security # ______________________

Employer Name ____

Job Title ____ Work Phone # ___________________

Date of Birth ____________ Age____ Gender ☐ Male ☐ Female Handedness? R L

Weight____________ Height ___________ Marital Status S M W D

Spouse's Name_________________________________ Spouse's Date of Birth ___________________

Person responsible for this account____

Health Insurance Company ______________________ Phone number__________________________

Policy/Member ID #______________________________ Group #_____________________________

Address _______________________________________ City _________________ Zip Code _________

Adjuster ____ Phone Number _____________________

Name of the insurance card holder____
Social Security # of card holder ______________________________

Name of their employer_____________________________ Employer Phone #____________________

Children names and ages____

Car Insurance Company ____

Address ____ City ________________ Zip Code _________

Adjuster ____ Phone #_________________________

Agent ____ Phone # __________________________

Policy # ______________________________________ Claim # _________________________________

Drivers License # ____

Name of Insured on your Car Policy _______________________ Date of Loss/Accident? ___________

Medical Coverage? ____________ Uninsured Motorist Coverage? ______________________________

Underinsured Motorist Coverage?____

Personal Injury Protection (PIP) Y N $____

Medical expenses to date as a result of the accident? $_______________________________________

Lost wages since accident $____

What is the repair amount of your car? $ ____

Lawyer/ Law Firm____ Phone #_____________________

Address _______________________________________City __________________Zip Code ___________

In case of emergency, whom should we contact?____

Phone #____

Family physician______________________________ Phone #____________________________________

Address______________________________________ City________________ Zip Code______________

Date you first saw any Doctor after accident ____

Is this Workman's Compensation? _________________Is this Personal Injury?______________________

Have you received any medical treatment since your accident? Y N

Hospital____Cost______________________________

Medical Doctor ____Cost______________________________

Chiropractor____Cost______________________________

Other____Cost______________________________

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ACCIDENT QUESTIONNAIRE

Patient's Name_____________________________ Date of incident __________Today's Date___________

DESCRIBE YOUR VEHICLE

1. **Vehicle Type** :
   a. Sports Car
   b. Coupe
   c. Sedan
   d. Sports Utility Vehicle
   e. Station Wagon
   f. Pick-up truck
   g. Bus
   h. Other: __________________________

   Make:__________________________________ Year:___________
   Model:___________________________ Estimated Speed:_________
2. **Vehicle Size:**
   a. Compact
   b. Mid-Sized
   c. Full-Sized

DESCRIBE THE ACCIDENT

3. **Date of Accident:** _______________________
4. **Actions of patient's vehicle:**
   a. crossing an intersection
   b. stopped at an intersection
   c. stopped for a pedestrian
   d. stopped for traffic
   e. traveling at posted speed limit
   f. traveling faster than the posted speed limit
   g. turning
5. **How was the patient's vehicle hit:**
   a. hit head-on
   b. was hit on the left front
   c. was hit on the right front
   d. was hit on the left rear
   e. was hit on the right rear
   f. was rear-ended
   g. Other: _______________________________
6. **Damage to patient's vehicle:**
   a. complete
   b. extensive
   c. minimal
   d. moderate
7. **Describe the second vehicle:**
   a. compact
   b. full size
   c. mid size
   d. semi trailer
   e. pick-up truck

   Make:__________________________________ Year:___________
   Model:___________________________ Estimated Speed:_________
8. **Damage to the other vehicle?**
   a. complete
   b. extensive
   c. minimal
   d. moderate
9. **Weather Conditions**
   a. Clear
   b. Cloudy
   c. Drizzling
   d. Foggy
   e. Rainy
   f. Snowy
   g. Stormy
   h. Sunny
10. **Road Conditions**
   a. Damp
   b. Dry
   c. Dry with icy patches
   d. Iced over
   e. Snowed over
   f. Wet

DESCRIBE THE MOMENT OF IMPACT

11. **Body position at time of impact:**
   a. leaning forward
   b. slouched down in seat
   c. straight
   d. turned to the left
   e. turned to the right
12. **Direction body was thrown:**
   a. backward then forward
   b. forward then backward
   c. to the left
   d. to the right
   e. about the vehicle
   f. outside the vehicle
   g. under the vehicle
13. **Head position at impact:**
   a. straight
   b. tilted forward
   c. turned to the left
   d. turned to the right
14. **Direction head was thrown:**
   a. backward then forward
   b. forward then backward
   c. side to side
15. **Type of restraint:**
   a. lap belt
   b. shoulder belt
   c. shoulder lap belt
16. **Place patient was seated in the vehicle:**
   a. Driver
   b. front passenger
   c. back passenger driver side
   d. back passenger right side
   e. back passenger middle
   f. other________________________________
17. **Did Airbags deploy:**
   a. yes
   b. no
18. **Were you seen at a Medical Facility following your accident:**
   a. Yes
   b. No

   If so name and address of the facility:

____

____

Patient Signature ____

SYMPTOMS

Patient's Name____________________________ Date of incident ___________Today's Date____________

CIRCLE ALL YOU COMPLIANTS

3. DO YOU HAVE LACERATIONS, CUTS OR BRUISING? :
   a. Head or Face
   b. Neck
   c. Seat belt bruising
   d. Cuts or bruising on your chest
   e. Cuts or bruising on arms
   f. Cuts or bruising on legs
   g. Other: _________________________

4. HEAD INJURIES: (now or at the time of the accident)
   a. Were you knocked out or unconscious
   b. Headaches
   c. Face pain
   d. Pupils different sizes
   e. Dizziness
   f. Difficulty walking
   g. Balance problems
   h. Room spins
   i. Disoriented Confusion
   j. Day dreaming
   k. Attention problems
   l. Hearing problems
   m. Change in sense of smell or taste
   n. Difficulty speaking
   o. Memory problems
   p. Very tired or fatigued
   q. Appetite change
   r. Sleep difficulties
   s. Visual Disturbances, blurry or double vision
   t. Flashbacks to accident
   u. Problems to read or write
   v. Problems adding or subtracting
   w. Problems learning new things
   x. Problems understanding
   y. Problems remembering numbers
   z. Difficulty Concentrating
   aa. Difficulty remembering things
   bb. Difficulty making decisions
   cc. Change in Sexual Functioning
   dd. Nausea / Vomiting
   ee. Change of personality
   ff. Wanting to be alone
   gg. Mood swings
   hh. Sadness
   ii. Agitation
   jj. Anger
   kk. Helplessness
   ll. Reduce confidence
   mm. Apathy
   nn. Irritability
   oo. Sleepiness
   pp. Frustration
   qq. Impatience
   rr. Other head related issues

      ____

5. JAW PROBLEMS:
   a. Jaw pain
   b. Clicking
   c. Pain while chewing
   d. Pain while talking
   e. Pain while yawning
   f. Pain while moving jaw from side to side

6. NECK INJURIES:
   h. Neck pain
   i. Neck pain, numbness, tingling, weakness that radiates or goes down to RIGHT shoulder, arm, forearm or hand
   j. Neck pain, numbness, tingling, weakness that radiates or goes down to LEFT shoulder, arm, forearm or hand
   k. Neck pain, numbness, tingling, weakness that radiates or goes down to RIGHT UPPER BACK
   l. Neck pain, numbness, tingling, weakness that radiates or goes down to LEFT UPPER BACK
   m. Neck pain that causes headaches
   n. Neck spasms or shoulder spasms
   o. Popping, clicking or clunking sound with neck movement

7. SHOULDER INJURIES
    h. Shoulder pain LEFT RIGHT BOTH
    i. Shoulder pain with movement L R BOTH
    j. Shoulder spasms LEFT RIGHT BOTH
    k. Sharp shoulder pain
    l. Dull shoulder pain
    m. Achy shoulder pain
    n. Pins and needles shoulder pain
    o. Shoulder pain that radiates or shoots pain into arm
    p. Other:

    ____

8. UPPER ARM PAIN: RIGHT LEFT BOTH
    e. Dull
    f. Ache
    g. Sharp
    h. Stabbing
    i. Other

    ____

9. ELBOW PAIN: RIGHT LEFT BOTH
    a. Dull
    b. Ache
    c. Sharp
    d. Stabbing
    e. Other

    ____

10. FOREARM: RIGHT LEFT BOTH
    a. Dull
    b. Ache
    c. Sharp
    d. Stabbing
    e. Other

    ____

11. WRIST PAIN: RIGHT LEFT BOTH
    a. Dull
    b. Ache
    c. Sharp
    d. Stabbing
    e. Other

    ____

12. HAND PAIN: RIGHT LEFT BOTH
    a. Dull
    b. Ache
    c. Sharp
    d. Stabbing
    e. Other

    ____

13. MID BACK PAIN OR UPPER BACK PAIN
    a. Upper or mid back pain
    b. Upper back pain, numbness, tingling, weakness that radiates or goes down to RIGHT shoulder, arm, forearm or hand
    c. Upper back pain, numbness, tingling, weakness that radiates or goes down to LEFT shoulder, arm, forearm or hand
    d. Upper or mid back spasms

14. LOW BACK PAIN:
    a. Low back pain
    b. Low back pain, numbness, tingling, weakness that radiates or goes down to RIGHT buttock, thigh, leg or foot
    c. Low back pain, numbness, tingling, weakness that radiates or goes down to LEFT buttock, thigh, leg or foot
    d. Low back spasms

15. PELVIC OR SACRAL PAIN
    a. Pelvic pain, numbness, tingling, weakness that radiates or goes down to RIGHT buttock, thigh, leg or foot
    b. Pelvic pain, numbness, tingling, weakness that radiates or goes down to LEFT buttock, thigh, leg or foot
    c. Sacral pain (tail bone)
    d. Coccygeal or coccyx (tail bone) pain

16. HIP PAIN: RIGHT LEFT BOTH
    a. Hip pain
    b. Hip pain, numbness, tingling, weakness that radiates or goes down to buttock, thigh, leg or foot

17. UPPER LEG PAIN: RIGHT LEFT BOTH
    a. Upper leg pain that radiates to knee
    b. Upper leg spasms

18. KNEE PAIN: RIGHT LEFT BOTH

   a. Knee pain that radiates to calf
   b. Knee pain that radiates to calf and ankle
   c. Knee pain that radiates to calf, ankle and foot

19. ANKLE PAIN: RIGHT LEFT BOTH

   a. Ankle pain that radiates to foot
   b. Ankle and foot pain

20. FOOT PAIN: RIGHT LEFT BOTH

21. CHEST PAIN

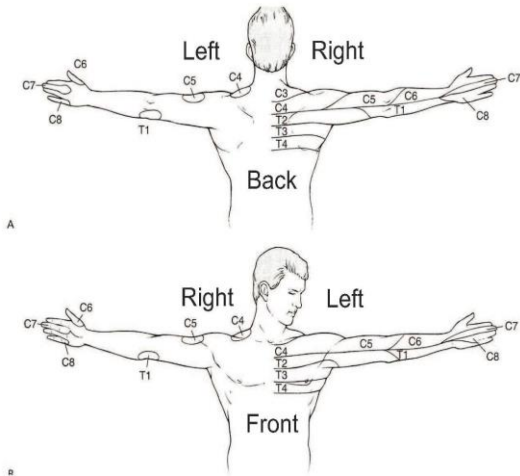
22. STOMACH PAIN

23. OTHER SYMPTOMS:
____
____
____
____

NECK AREA CONSULTATION (1 of 2 pages)

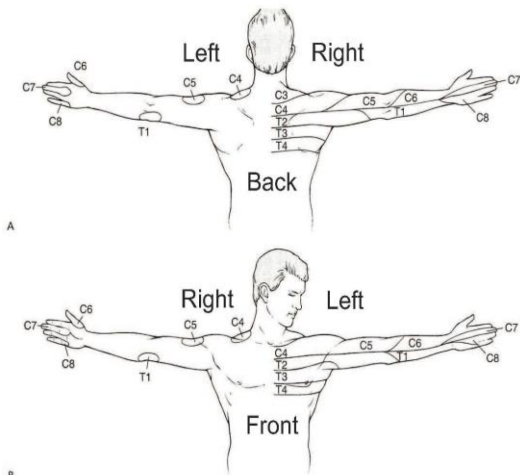
Patient's Name______________________________ Date of Injury____________ Today's Date____________

Please shade in all areas on this picture where you have had **PAIN** in the past 7 days



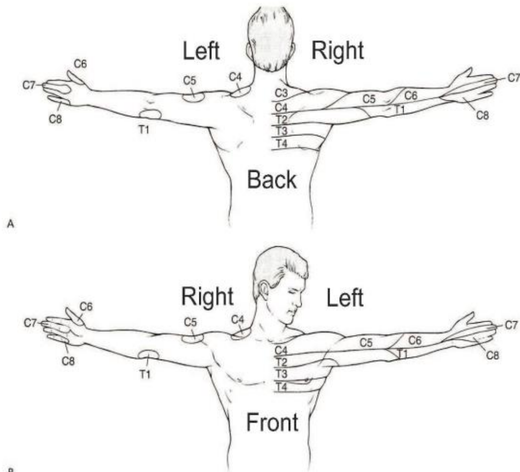
Area	Severity	% of Time	Sharp?	Dull?	Ache?	Other
C4	/10	%				
C5	/10	%				
C6	/10	%				
C7	/10	%				
C8	/10	%				
T1	/10	%				
T2	/10	%				
T3	/10	%				
T4	/10	%				

Shade in all areas of **ALTERED SENSATION (i.e. PINS/NEEDLES, NUMB, TINGLING)** in the past 7 days



Area	Severity	% of Time	Sharp?	Dull?	Ache?	Other
C4	/10	%				
C5	/10	%				
C6	/10	%				
C7	/10	%				
C8	/10	%				
T1	/10	%				
T2	/10	%				
T3	/10	%				
T4	/10	%				

Shade in all areas of **WEAKNESS, CLUMSINESS, DROPPING THINGS** in the past 7 days



Area	Severity	% of Time	Sharp?	Dull?	Ache?	Other
C4	/10	%				
C5	/10	%				
C6	/10	%				
C7	/10	%				
C8	/10	%				
T1	/10	%				
T2	/10	%				
T3	/10	%				
T4	/10	%				

NECK AREA CONSULTATION (2 of 2 pages)

Patient's Name_____________________________ Date of Injury____________ Today's Date____________

☐ I have had **FUNCTIONAL DIFFICULTIES** because of NECK PAIN in the past 7 days

Describe how NECK PAIN is affecting your normal daily activities_________________________________

____

____

EXACERBATING FACTORS (Check all below that make your NECK hurt more)

☐ Laying on pillow ☐ Turning neck ☐ Looking up ☐ Looking Down ☐ Combing hair

☐ Computer at work ☐ Computer at home ☐ Working ☐ Sports ☐ Driving

☐ Others (please list other things that make your neck hurt ___________________________________

____

____

ALLEVIATING FACTORS (Check all below that make your NECK feel better)

☐ Doctor treatments Helps for ________ Hours Days Weeks Months

☐ Medications Helps for ________ Hours Days Weeks Months

☐ Home Exercises Helps for ________ Hours Days Weeks Months

☐ __________________ Helps for ________ Hours Days Weeks Months

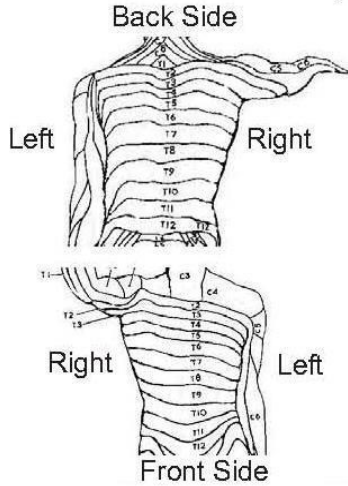
☐ __________________ Helps for ________ Hours Days Weeks Months

☐ __________________ Helps for ________ Hours Days Weeks Months

Upper Back Area Consultation (1 of 2 pages)

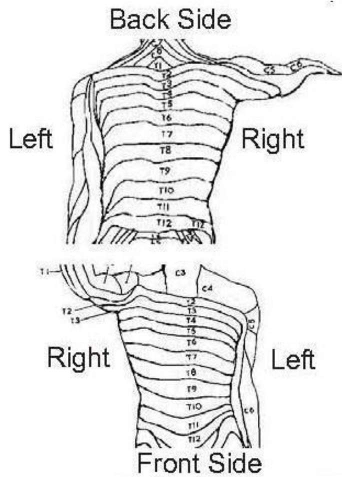
Patient's name____________________________ Date of Injury___________ Today's Date____________

Please shade in all areas on this picture where you have had **PAIN** in the past 7 days



Area	Severity	% of Time	Sharp?	Dull?	Ache?	Other
T11	/10	%				
T12	/10	%				
L1	/10	%				
L2	/10	%				
L3	/10	%				
L4	/10	%				
L5	/10	%				
S1	/10	%				
S2-5	/10	%				

Shade in all areas of **ALTERED SENSATION (I.E. PINS/NEEDLES, NUMB, TINGLING)** in the past 7 days



Area	Severity	% of Time	Sharp?	Dull?	Ache?	Other
T11	/10	%				
T12	/10	%				
L1	/10	%				
L2	/10	%				
L3	/10	%				
L4	/10	%				
L5	/10	%				
S1	/10	%				
S2-5	/10	%				

☐ I am having **FUNCTIONAL DIFFICULTIES** because of UPPER BACK PAIN in the past 7 days

Describe how UPPER BACK PAIN is affecting your normal daily activities ________________________

____

EXACERBATING FACTORS (Check all below that make your LOW BACK hurt more)

☐ Laying in bed ☐ Sitting ☐ Bending ☐ Twisting ☐ Lifting ☐ Dressing

☐ Computer at work ☐ Computer at home ☐ Working ☐ Sports ☐ Driving

☐ Others (please list other things that make your UPPER BACK hurt) ____________________________

____

Upper Back Area Consultation (2 of 2 pages)

Patient's name_____________________________ Date of Injury___________ Today's Date____________

ALLEVIATING FACTORS (Check all below that make your UPPER BACK feel better)

☐ In-Office Treatments Helps for ________ Hours Days Weeks Months

☐ Medications Helps for ________ Hours Days Weeks Months

☐ Home Exercises Helps for ________ Hours Days Weeks Months

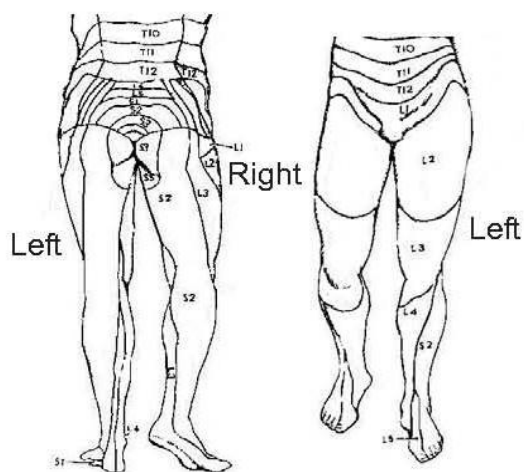
☐ _________________ Helps for ________ Hours Days Weeks Months

☐ _________________ Helps for ________ Hours Days Weeks Months

Low Back & Pelvis Area Consultation (1 of 2 pages)

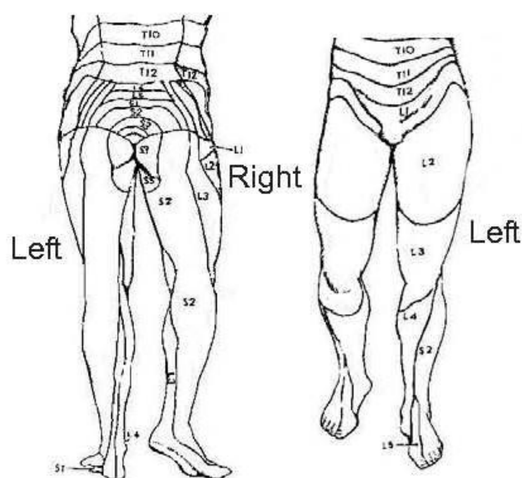
Patient's name________________________________ Date of Injury___________ Today's Date____________

Please shade in all areas on this picture where you have had **PAIN** in the past 7 days



Area	Severity	% of Time	Sharp?	Dull?	Ache?	Other
T11	/10	%				
T12	/10	%				
L1	/10	%				
L2	/10	%				
L3	/10	%				
L4	/10	%				
L5	/10	%				
S1	/10	%				
S2-5	/10	%				

Shade in all areas of **ALTERED SENSATION (I.E. PINS/NEEDLES, NUMB, TINGLING)** in the past 7 days



Area	Severity	% of Time	Sharp?	Dull?	Ache?	Other
T11	/10	%				
T12	/10	%				
L1	/10	%				
L2	/10	%				
L3	/10	%				
L4	/10	%				
L5	/10	%				
S1	/10	%				
S2-5	/10	%				

☐ In my Low Back or Legs, **WEAKNESS, STUMBLING, BUMPING INTO THINGS** in the past 7 days

☐ I am having **FUNCTIONAL DIFFICULTIES** because of LOW BACK PAIN in the past 7 days

Describe how LOW BACK PAIN is affecting your normal daily activities _________________________

____

EXACERBATING FACTORS (Check all below that make your LOW BACK hurt more)

☐ Laying in bed ☐ Sitting ☐ Bending ☐ Twisting ☐ Lifting ☐ Pushing/Pulling

☐ Computer at work ☐ Computer at home ☐ Working ☐ Sports ☐ Driving

☐ Others (please list other things that make your LOW BACK hurt) ____________________________

____

Low Back & Pelvis Area Consultation (2 of 2 pages)

Patient's name______________________________ Date of Injury___________ Today's Date____________

ALLEVIATING FACTORS (Check all below that make your LOW BACK feel better)

☐ In-Office Treatments	Helps for ________	Hours	Days	Weeks	Months
☐ Medications	Helps for ________	Hours	Days	Weeks	Months
☐ Home Exercises	Helps for ________	Hours	Days	Weeks	Months
☐ _________________	Helps for ________	Hours	Days	Weeks	Months
☐ _________________	Helps for ________	Hours	Days	Weeks	Months