DERRICK FAMILY CHIROPRACTIC

Automobile Accident History

3535 MARTIN WAY E
OLYMPIA, WA 98506
360.491-9135

Welcome!

ABOUT YOU…

DATE _____

NAME: _____ M.I. _____ M / F I PREFER TO BE CALLED: _____

BIRTHDATE: _____ AGE: _____ SSN: _____ HEIGHT: _____ WEIGHT: _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

PHONE(S): HOME: _____ CELL: _____ WORK: _____

REFERRED BY: _____ EMPLOYER: _____

OCCUPATION / JOB DESCRIPTION: _____ EMAIL: _____

MARITAL STATUS: S M D SPOUSE'S NAME: _____ SPOUSE'S BIRTHDATE: _____

EMERGENCY CONTACT…

WHOM SHOULD WE CONTACT? _____ RELATION: _____

PHONE(S): HOME: _____ CELL: _____ WORK: _____

REASON FOR YOUR VISIT…

DATE OF ACCIDENT: _____ TIME OF ACCIDENT: _____ AM / PM

ACCIDENT LOCATION (STREET, CITY, COUNTY, STATE): _____ AT FAULT? YES / NO

PLEASE DESCRIBE WHAT HAPPENED: _____

_____

_____

WERE POLICE ON THE SCENE? YES / NO EMERGENCY VEHICLES? YES / NO TRAFFIC CONDITIONS? LIGHT / MOD / HEAVY

ROAD CONDITIONS? WET DRY ICY GRAVEL OTHER: _____

WERE YOU THE: DRIVER OR PASSENGER? IF PASSENGER: FRONT SEAT / BACKSEAT / LEFT SIDE / RIGHT SIDE

WERE YOU WEARING A SEATBELT? Y / N DID YOU HAVE A PROPERLY POSITIONED HEADREST? Y / N AIRBAGS DEPLOY? Y / N

WERE YOU AWARE OF THE IMPENDING COLLISION? Y/N

DO YOU RECALL HITTING YOUR HEAD? Y/N LOSING CONSCIOUSNESS? Y/N

WAS YOUR HEAD UPRIGHT/FORWARD AT IMPACT? Y / LEFT / RIGHT TORSO UPRIGHT/FORWARD AT IMPACT? Y / LEFT / RIGHT

WERE HANDS ON STEERING WHEEL? LEFT / RIGHT WAS FOOT ON? BRAKE / CLUTCH BRUISING (WHERE)? _____

WAS YOUR VEHICLE? MOVING / STOPPED / SLOWING / ACCELERATING IMPACTS AFTER INITIAL COLLISION? YES / NO _____

WERE YOU TAKEN TO THE HOSPITAL? YES / NO IF SO, WHERE? _____

WERE X-RAYS TAKEN? YES / NO WHAT DIAGNOSIS WERE YOU GIVEN? _____

ANY CURRENT MEDICATION? YES / NO NAMES OF MEDS: _____

WHAT ADVICE WERE YOU GIVEN? _____

HAVE YOU RECEIVED OTHER CARE SINCE? YES / NO KIND/LOCATION? _____

HAVE YOU EVER BEEN TREATED BY A CHIROPRACTOR BEFORE? YES / NO HOW LONG AGO? _____

SYMPTOMS…

REGARDING YOUR CURRENT SYMPTOMS: DO YOU HAVE THE FOLLOWING? ALSO, PLEASE RATE YOUR PAIN ON A SCALE OF 1 TO 10.

HEADACHES? YES / NO / LEFT / RIGHT ___ /10 DESCRIBE: _____

NECK PAIN? YES / NO / LEFT / RIGHT ___ /10 DESCRIBE: _____

MID BACK PAIN? YES / NO / LEFT / RIGHT ___ /10 DESCRIBE: _____

LOW BACK PAIN? YES / NO / LEFT / RIGHT ___ /10 DESCRIBE: _____

ARM PAIN? YES / NO / LEFT / RIGHT ___ /10 DESCRIBE: _____

LEG PAIN? YES / NO / LEFT / RIGHT ___ /10 DESCRIBE: _____

OTHER? YES / NO / LEFT / RIGHT ___ /10 DESCRIBE: _____

OTHER? YES / NO / LEFT / RIGHT ___ /10 DESCRIBE: _____

HOW HAS THE ACCIDENT AFFECTED YOUR?

WORK: _____

SLEEP: _____

HOBBIES / ACTIVITIES OF DAILY LIVING: _____

HEALTH HISTORY…

HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS? (CIRCLE)

HEADACHES	CHEST PAIN	SEIZURE / EPILEPSY
NECK PAIN	DIFFICULTY BREATHING	HEART CONDITION
NUMBNESS / TINGLING	HIGH/LOW BLOOD PRESSURE	LIVER CONDITION
DIZZINESS / FAINTING	HIV / AIDS	HEPATITIS
MID BACK PAIN	CANCER	KIDNEY CONDITION
ARM / LEG PAIN	ASTHMA	FREQUENT URINATION
LOW BACK PAIN	ARTHRITIS	DIABETES
HIP PAIN	ARTIFICIAL JOINTS	FIBROMYALGIA / CHRONIC FATIGUE

OTHERS _____

LIST PREVIOUS SURGERIES/TRAUMAS/HOSPITALIZATIONS: _____

_____

LIST PAST ACCIDENTS: _____

DO YOU USE TOBACCO? YES / NO HOW MUCH? _____ HOW LONG? _____

DO YOU USE ALCOHOL? YES / NO HOW MUCH? _____ HOW LONG? _____

WOMEN: BIRTH CONTROL? YES/NO PREGNANT? YES/NO HOW LONG? _____ LAST MENSES: _____

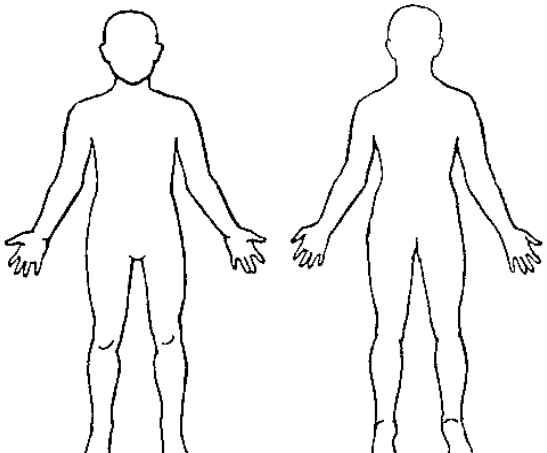
TO AID IN THE EVALUATION OF YOUR CONDITION, PLEASE MARK THE AREAS INVOLVING YOUR PAIN WITH THE FOLLOWING KEY:

P FOR PAIN

B FOR BURNING

A FOR ACHING

S FOR STABBING



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N FOR NUMBNESS / TINGLING

INSURANCE INFO…

YOUR AUTO INSURANCE CO: _____

ADDRESS: (STREET, CITY, STATE, ZIP): _____

HAS YOUR INSURANCE COMPANY BEEN NOTIFIED OF THE ACCIDENT? YES / NO

POLICY NUMBER: _____ CLAIM NUMBER: _____

DOES **YOUR** POLICY HAVE PERSONAL INJURY PROTECTION (PIP)? YES / NO UNINSURED MOTORIST COVERAGE? YES / NO

OTHER VEHICLE'S DRIVER'S NAME: _____ ADDRESS: _____

AT FAULT AUTO INSURANCE CO: _____

ADDRESS: (STREET, CITY, STATE, ZIP): _____

POLICY NUMBER: _____ CLAIM NUMBER: _____

DO YOU HAVE AN ATTORNEY FOR THIS CASE: YES / NO NAME OR FIRM: _____

- WE INVITE YOU TO DISCUSS WITH US ANY QUESTIONS REGARDING OUR SERVICES. THE BEST HEALTH SERVICES ARE BASED ON A FRIENDLY, MUTUAL UNDERSTANDING BETWEEN PROVIDER AND PATIENT.
- OUR POLICY REQUIRES PAYMENT IN FULL FOR ALL SERVICES RENDERED AT THE TIME OF VISIT, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. IF ACCOUNT IS NOT PAID WITHIN A REASONABLE TIME AND NO FINANCIAL ARRANGEMENTS HAVE BEEN MADE, YOU WILL BE RESPONSIBLE FOR ANY EXPENSES INCURRED IN COLLECTING YOUR ACCOUNT.
- WE WILL ATTEMPT TO BILL YOUR INSURANCE OR RESPONSIBLE PARTY AS A COURTESY, HOWEVER, YOUR ACCOUNT IS YOUR RESPONSIBILITY.
- I AUTHORIZE THE STAFF TO PERFORM ANY NECESSARY SERVICES NEEDED DURING DIAGNOSIS AND TREATMENT. I ALSO AUTHORIZE THE PROVIDER TO RELEASE ANY INFORMATION REQUIRED TO PROCESS INSURANCE CLAIMS.
- I AUTHORIZE ASSIGNMENT OF MY INSURANCE RIGHTS AND BENEFITS DIRECTLY TO THE PROVIDER FOR SERVICES RENDERED.
- I UNDERSTAND THAT ALTHOUGH CHIROPRACTIC CARE HAS BEEN PROVEN TO BE SAFE AND EFFECTIVE, THERE ARE RISKS WITH ALL TYPES OF CARE. THESE RISKS MAY INCLUDE, BUT ARE NOT LIMITED TO, AGGRAVATION OF PAIN, TEMPORARY SORENESS, OR INEFFECTIVENESS.
- I UNDERSTAND THE ABOVE INFORMATION AND GUARANTEE THIS FORM WAS COMPLETED CORRECTLY TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY HEALTH OR PERSONAL STATUS.

SIGNATURE: _____ DATE: _____