phillipsfamily CHIROPRACTIC

Confidential Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date _____
First Middle Initial Last

Address _____ City _____ State _____ Zip _____

Sex: ❑ Female ❑ Male **Birthdate** _____ E-mail _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone(____) _____

Do you prefer to receive calls at: ❑ Home ❑ Work ❑ Cell ❑ No Preference

❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered

Patient Employer/School _____ Occupation _____

Employer/School Address _____ City _____ State _____ Zip _____

Spouse or Parent's name _____ Employer _____

Whom may we thank for referring you to us? _____ Family Physician _____

Person to contact in case of emergency _____ Phone (____) _____

Insurance Information

Please check the type of insurance that applies to your case: Please list Auto Insurance.

☑ Auto Accident ❑ Work Injury ❑ Group ❑ Medicare ❑ Other

If Auto Accident or Work Injury: Date of Injury _____

Name of insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____

Name of employer _____ Work Phone (____) _____

Insurance Co. _____ Group # _____

Insurance ID# _____

Auto Accident/Work Injury/Medicare Patients Only

Do you have additional insurance? If so, complete the following: Please list your Private Insurance.

Name of insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date employed _____

Name of employer _____ Work Phone (____) _____

Insurance Co. _____ Group # _____

Insurance ID# _____

Expectations/Desires for Care

- ❑ **Acute Care** (I am interested in relief from my current pain or condition only)
- ❑ **Wellness Care** (I am interested in participating in care that helps me to remain healthy when I am no longer in acute pain)

In addition to my chiropractic care, I would be interested in utilizing the following additional methods of getting and staying healthy:

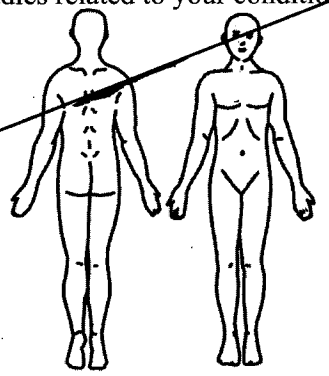
- ❑ **Massage Therapy:** A helpful adjunct to your chiropractic care. Useful in treating and managing a number of different health conditions.
- ❑ **Nutrition:** Attention to proper diet and supplementation needs can "Help your body to help itself"
- ❑ **Exercise/Stretching:** It truly is "the best medicine". Exercise and stretching can be used to rehabilitate an injured area or to maintain and improve your health.

Patient Condition See Vehicle Accident Form

Reason for today's visit: _____
When did your symptoms first appear?: _____
What occurred to contribute to the onset of your symptoms? _____
_____
Rate the severity of your pain: 1 2 3 4 5 6 7 8 9 10
Is the pain constant or does it come and go? (Circle correct answer)
Has the intensity of your pain been getting better, worse or staying the same? (Circle the correct answer)
Activities or movements that are painful to perform: ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down
Other treatments for this condition: ❑ Medication ❑ Physical Therapy ❑ Massage ❑ Surgery
Are there any existing diagnostic studies related to your condition or area of complaint? Yes/No

Please indicate the location of your **pain** by placing an "X" over the involved area(s).

Please indicate any areas of **numbness or tingling** by placing a "✓" over the involved area(s).



Any additional information on your condition you would like to add: _____
_____
_____
_____
_____

✳ Please list all medications currently used (Prescription or Over the Counter): _____
_____
_____
Please list all nutritional supplements currently used: _____
_____
Do you exercise? _____ If so, what type? _____ How often? _____

✳ Health History

❑ AIDS/HIV	❑ Diabetes	❑ High Blood Pressure	❑ Osteopenia	❑ Spinal Surgery
❑ Allergy Shots	❑ Emphysema	❑ High Cholesterol	❑ Osteoporosis	❑ Stroke
❑ Anemia	❑ Epilepsy	❑ Irritable Bowel Synd.	❑ Pacemaker	❑ Thyroid Problems
❑ Arthritis	❑ Fibromyalgia	❑ Joint Replacement	❑ Parkinson's Disease	❑ Tuberculosis
❑ Asthma	❑ Glaucoma	❑ Kidney Disease	❑ Polio	❑ Tumors
❑ Breast Cancer	❑ Gout	❑ Liver Disease	❑ Prostate Problems	❑ Ulcers
❑ Cancer	❑ Heart Disease	❑ Meniere's Disease	❑ Psoriasis	❑ Vertigo
❑ Carotid Artery Surgery	❑ Hepatitis	❑ Migraine Headaches	❑ Rheumatoid Arthritis	❑ Other _____
❑ Chronic Fatigue Synd.	❑ Hernia	❑ Mononucleosis	❑ Shoulder Surgery	_____
❑ Colitis	❑ Herniated Disc	❑ Multiple Sclerosis	❑ Spinal Fractures	_____

Female Specific

Are you currently pregnant? Yes/No Date of last menstrual flow: _____
Are you currently experiencing symptoms associated with menopause? Yes/No
Are you post-menopausal? Yes/No If so, for how long? _____

✳ Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)
and assign directly to Phillips Family Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

✳ _____ ✳ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date_____

Patient Name_____

Date of Accident_____ Time of Accident_____ ☐ a.m. ☐ p.m.

Please describe the accident in your own words:_____

_____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle?_____

ACCIDENT SITE

Road/Street Name_____

City/State_____

Nearest intersection with road/street_____

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other _____

Which direction were you headed?_____

Speed you were traveling?_____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain_____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain_____

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other_____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

OTHER VEHICLE
(If applicable)

Make and model of other vehicle_____

Which direction was other vehicle headed?_____

Speed other vehicle was traveling_____

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom?_____

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?_____

Please describe how you felt immediately after the accident:

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital_____ Name of doctor_____

Diagnosis_____

_____

Treatment received_____

X-rays taken_____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?_____

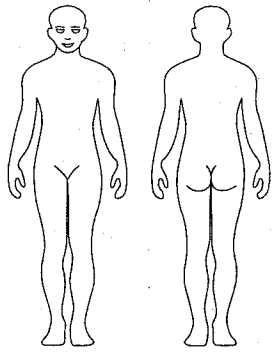
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

☐ Arm/shoulder pain	☐ Feet/toe numbness	☐ Neck pain
☐ Back pain	☐ Hand/finger numbness	☐ Neck stiff
☐ Back stiffness	☐ Headaches	☐ Shortness of breath
☐ Chest pain	☐ Irritability	☐ Sleep difficulty
☐ Dizziness	☐ Jaw problems	☐ Stomach upset
☐ Ear buzzing	☐ Leg pain	☐ Tension
☐ Ear ringing	☐ Memory loss	☐ Vision blurred
☐ Fatigue	☐ Nausea	

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
☐ Cramps	☐ Stiffness	☐ Swelling	☐ Other_____

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient