Auto/Personal Accident Patient Information

PATIENT

Name: _____ S.S #_____ Home#: _____

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

E-mail: _____ Cell#:_____ Age: _____ Birth Date: _____

Circle Marital Status: Married Single Widow Divorced Separated How many children? _____

WOMEN ONLY Are you, or is there any possibility that you may be pregnant? Yes❑ No❑ Uncertain❑

How did you hear about our office? _____

EMPLOYER

Occupation: _____ Company Name: _____

Address: _____ Phone#: _____

EMERGENCY CONTACT

Name:_____ Relationship:_____ Phone#:_____

ACCIDENT INFORMATION

Date of Accident: _____ Time: _____ Location:_____ Was Police notified? Yes❑ No❑

Was it a slip & fall or did you get hit?_____

Car Accident - Where you the: Driver ❑ Front Seat Passenger ❑ Back Seat Passenger ❑

Number of people in your vehicle? _____ Were you wearing seat belts? Yes❑ No❑

Approximate speed of your vehicle: _____mph Other vehicle: _____mph

Where you knocked unconscious? Yes❑ No❑ If yes for how long?_____

Please describe how you felt during the accident? _____

Immediately after the accident ? _____

Later that day?_____

The next day? _____

Where you taken to the Hospital? Yes❑ No❑ If yes where? _____ By ambulance? Yes❑ No❑

Have you seen another doctor for this accident? Yes❑ No❑ If yes by who? _____

As a result of the accident, are you taking medications? Yes❑ No❑ If yes what? _____

Have you lost time from work due to this accident? Yes ❑ No ❑ If yes what dates? _____

Are you being paid for time lost from work? Yes ❑ No ❑ If yes by who? _____

Do you have an ATTORNEY: Yes❑ No❑ If yes who?: _____

Address:_____ Phone#:_____ Fax#:_____

INSURANCE

Your Ins. Co._____ Phone#:_____ Agent Name:_____

Name on Policy_____ Policy#:_____ Claim#:_____

RESPONSIBLE Party's Name: _____ Phone: _____

Ins. Co.:_____ Phone#: _____ Agent Name: _____

Name on Policy_____ Policy#:_____ Claim#:_____

What are your PRESENT complaints?_____

_____

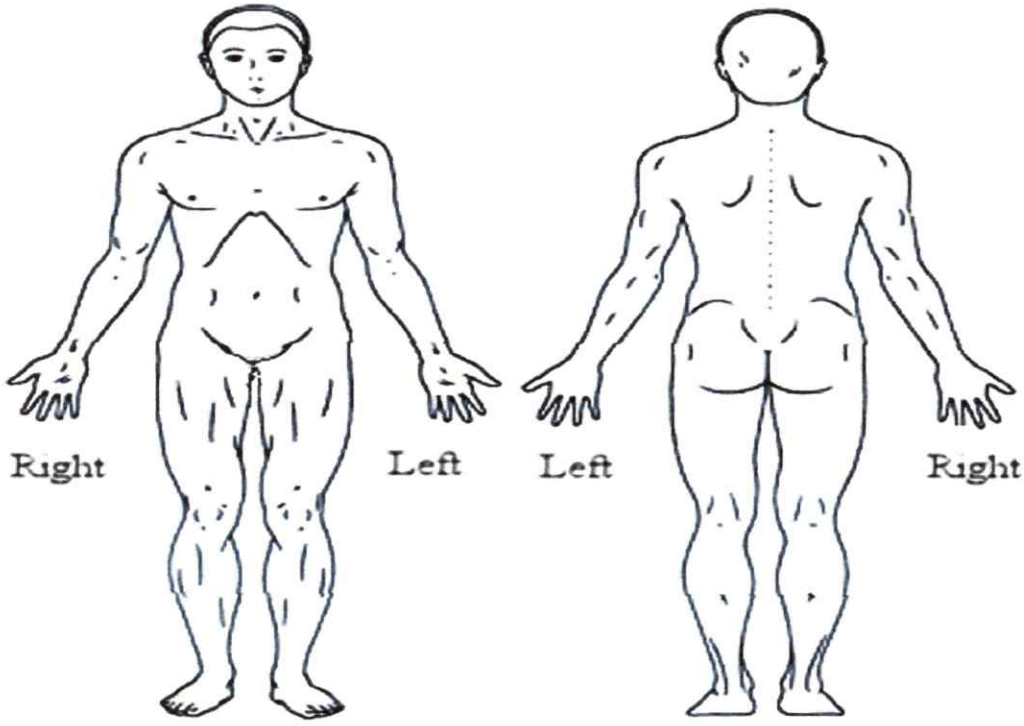
Since the accident occurred are you symptoms ❑Improving ❑Getting Worse ❑Same

Did you have any physical or illnesses Complaints BEFORE THE ACCIDENT? Yes❑ No❑ If yes, describe:

_____

Have you ever been involved in an accident before? Yes❑ No❑ If yes describe dates, injuries received and what type of accident's:_____

Mark on the pictures where you feel pain.



Please circle your pain level, 0 means no pain and 10 means severe pain. 0 1 2 3 4 5 6 7 8 9 10

Make model and year of the your car?_____

Amount of damaged to your car? _____

Make model and year of the other cars involved? _____

I authorize payment of insurance directly to Steven R Davis D.C. & Davis Chiropractic to release all information necessary to anyone to communicate with to secure the payment of benefits. I understand and agree that all services rendered me are charged directly to me and that 1 am personally responsible for payment. 1 also understand that if 1 suspend or terminate my care and treatment, any fees for professional services rendered me will immediately be due and payable. I understand that interest is charged on overdue accounts at the annual rate of 15%. California State Law requires we maintain your X-Rays. The film itself is the property of this office. Films may be loaned to another facility with authorization only.

Signature:_____ Date: _____

□ Patient □ Father/Mother □ Legal Guardian

Name:_____ Date:_____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Carry Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

_____

_____

Patient signature: _____ **Today's Date:** __/__/__

Continued on next page

Name:_____ Date:_____

QUADRUPLE VISUAL ANALOGUE SCALE

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain 0 1 (2) 3 4 (5) 6 7 (8) 9 10 worst possible pain

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1 – What is your pain RIGHT NOW?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

2 – What is your TYPICAL or AVERAGE pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

OTHER COMMENTS:

_____

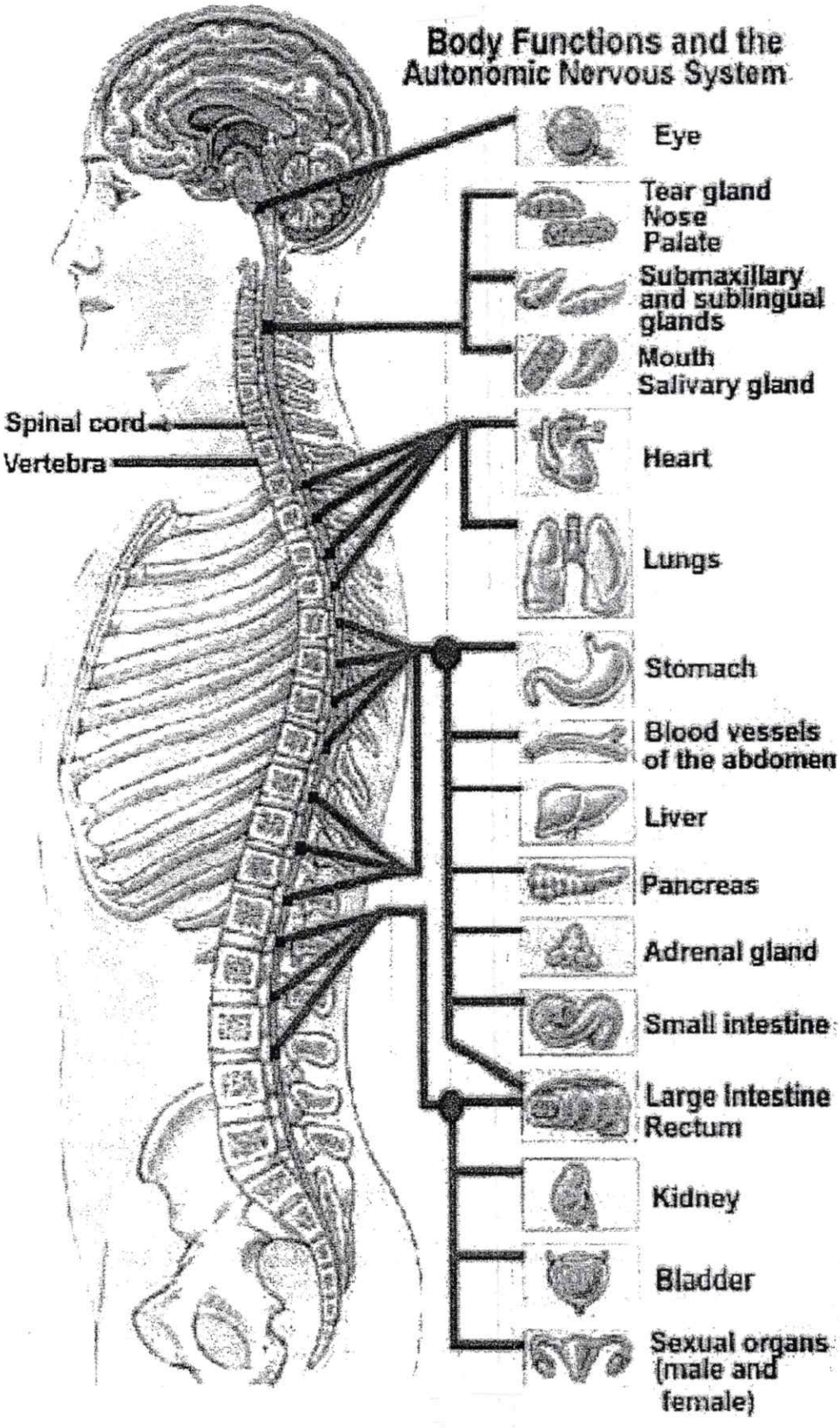
_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Name: _____ Date: _____



- ☐ Neck Pain
- ☐ Headaches & Migraines
- ☐ Pain behind Eyes or Blurriness
- ☐ Shoulder Pain or Weakness
- ☐ Arm/hand Pain or Numbness
- ☐ Cold Hands or Feet
- ☐ High Blood Pressure
- ☐ Nervous Breakdowns
- ☐ Tiredness
- ☐ Dizziness
- ☐ Ear Infections
- ☐ Sinus Pressure / Allergies
- ☐ Ringing/Buzzing Ears
- ☐ Sore Throat / Throat Infections
- ☐ Insomnia
- ☐ Loss of Memory
- ☐ Inability to Concentrate
- ☐ Mid Back Pain
- ☐ Rib
- ☐ Chest Pain
- ☐ Heart Palpitations
- ☐ Asthma
- ☐ Upper Respiratory Problems or Bronchitis
- ☐ Constipation / Diarrhea
- ☐ Excessive Gas / Bloating
- ☐ Stomach/Abdominal Pain or Cramps
- ☐ Indigestion / Heart Burn /Acid Reflux
- ☐ Excessive Menstrual Cramping
- ☐ Low Back/Pelvic/Hip Pain
- ☐ Sciatica
- ☐ Leg/Knee/Foot Pain
- ☐ Leg/Knee/Feet Weakness/Cramps or Swelling
- ☐ Poor Leg Circulation
- ☐ Hernias
- ☐ Excessive or Frequent Urination
- ☐ Prostrate Problems
- ☐ Urinary Infections
- ☐ Impotence / Infertility
- ☐ Pain at the end of the spine on sitting
- ☐ Buttocks Pain or Numbness
- ☐ Problems with Rectums
- ☐ Hemorrhoids
- ☐ Spinal Curvatures