

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Cell Phone: _____ Date: _____
Patient: _____ Date of Birth: _____ SSN: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ No. of Children _____
Employer: _____ Address: _____
Name of Spouse/Guardian: _____ Date of Birth: _____
Spouse's/Guardian's Employer: _____ Address: _____
How did you learn of this clinic? _____
Emergency Contact: _____ Phone: _____ Relationship: _____

YOUR INSURANCE COMPANY: _____ Phone No: _____ Policy No.: _____
Name/phone of agent who contacted you: _____ Claim No.: _____
Name of driver of vehicle in which you were injured (self or other): _____

INSURANCE COMPANY: _____ Phone No: _____ Policy No.: _____
Name/phone of agent who contacted you: _____ Claim No.: _____

Date of Accident: _____ Time: _____ AM PM Location: _____
Have you retained an attorney? Yes No Not yet
If so, his/her name, address & phone #: _____
Have you ever had any complaints in the involved area before? Yes No
If so, what were the complaints? _____
Before the injury, were you capable of working on an equal basis with others your age? Yes No
Are your work activities restricted as a result of this accident? Yes No
Since the injury, are your symptoms Improving? Getting worse? The same?
Other Doctor seen for this condition: _____
Have you been treated by a doctor for any other health condition in the last year? Yes No
If yes, please describe: _____
List any medications you are currently taking: _____

PAYMENT POLICY

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Durham Family Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Durham Family Chiropractic will be credited to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am responsible for payment. I also understand that if I suspend or terminate my treatment, any fees for professional services rendered to me will be immediately due and payable. If I cannot keep your appointment and I do not call or email the office prior to my appointment time I understand that I will be charged a fee of \$25.00

Signature of Physician: _____ Signature of Patient: _____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whom ever he/she may designate as his/her assistants to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care or any clinic services he/she deems necessary in my case; and I further authorize the him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, worker's compensation carriers, welfare funds or the patient's employer.

Signature of Patient: _____ Parent's/Guardian's Signature: _____

HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Patient: _____ Date: _____ No: _____

MUSCULOSKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder problems

GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

ARE YOU PREGNANT?

- YES NO

GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficulty chewing
- Difficulty swallowing
- Excessive thirst
- Nausea
- Vomiting blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

CARDIO-VASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficulty breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

EYE, EAR, NOSE & THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficulty breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficulty with speech
- Sinus
- Allergy
- Jaw pain

NERVOUS SYSTEM

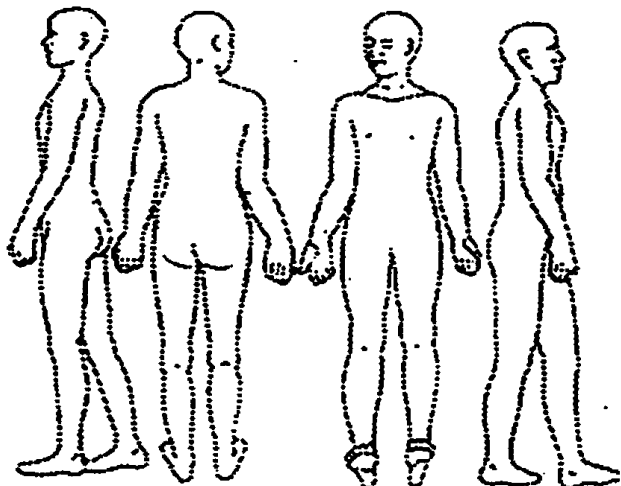
- Numbness
- Loss of Feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscle Jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

HABITS

- Smoking
- Alcohol use
- Coffee or tea:
- Drug abuse
- _____

PLEASE MARK ON THE BODY WHERE YOU EXPERIENCE THE FOLLOWING SYMPTOMS:

- P ___ Pain T ___ Tender
 N ___ Numb H ___ Hypoesthesia
 S ___ Spasm (decrease of sensitivity)



Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient Signature: _____