IF ACCIDENTAL INJURY PLESE COMPLETE THE FOLLOWING QUESTIONS

Date of Accident:_____________ _Hour___________ AM ________PM Location___________________________

How Did Accident Occur? ☐ Auto Collision ☐ On-the-job injury ☐ Other____________________________

If Not An Auto Collision, Please Describe The Circumstances ______________________________________

____

____

Did You Report The Injury To Your Foreman or Employer? ☐ YES ☐ NO

Did He (They) Recommend Care At Our Office? ☐ YES ☐ NO

If Auto Accident, Were You Driver ☐ Passenger ☐ Pedestrian ☐

If Auto Collision Were You Struck From Behind ☐ Right Side ☐ Left Side ☐ Front ☐ Auto Was Parked ☐

Did Your Car Strike The Other(s) Involved ☐YES ☐NO; Did The Other Car Strike Yours? ☐YES ☐NO ☐Undetermined

As A Result Of the Accident Were Traffic Citations Issued To You? ☐YES ☐NO; To the Driver of the other car ☐YES ☐NO

To the Driver of Your Car ☐YES ☐NO

List the Extent of the Injuries as You Know Them ____

____

____

Did you require Post-Accident Hospitalization? ☐ YES ☐ NO

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head Seems Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins & Needles in Arms	☐ Lights Bother Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ ____________

Symptoms Other Than Above ____

____

Have You Lost Any Days of Work? ☐YES ☐ NO Dates:____

Insurance Companies Involved:

My Insurance Company____

Company of Person Responsible for Injuries____

Claim #_______________________________________

Have You Been Contacted By an Insurance Adjuster or Company Representative Regarding This Claim ☐ YES ☐ NO

Do You Have an Attorney That Has Advised You In This Case? ☐ YES ☐ NO

Name____

Address____

Telephone____

WELCOME

To

ACT CHIROPRACTIC

ANDREW C. TWITCHELL, D.C.

Date______________________

PATIENT INFORMATION

Patient______________________________

Address______________________________

____

City **State** **Zip**

Sex: ☐M ☐F Age_______ **Birthdate**____________

Ht___________ Wt___________

Marital Status: ☐Single ☐Married ☐Widow

☐Sep ☐Divorced **SS#**____________________

Occupation______________________________

Employer Address______________________________

Employer Phone______________________________

Spouse/Parent Name______________________________

Birthdate____________Occupation____________

Employer______________________________

Whom may we thank for referring you?

____

PHONE NUMBERS

Home______________ **Cell/Work**______________

Best time & place to reach you______________

____

IN CASE OF EMERGENCY, CONTACT:

Name____________________ Relationship__________

Home Phone______________Work______________

Reason for visit______________________________

____

When did your symptoms begin? ______________

Have you had this or similar conditions in the past? ☐Yes ☐No

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 you pain on a scale from 1 to 10 _______

Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Shooting ☐Aching ☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Other

How often do you have this pain? ☐Constant ☐Comes & Goes

Interferes with: ☐Work ☐Sleep ☐Daily Routine ☐Recreation.

Painful activities: ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down

HEALTH HITORY

What Operations Have You Had?______________________

____

When?____________ Serious Illnesses?______________

When?______________

Check if you have suffered from: ☐Backaches ☐Arthritis ☐Dizziness ☐Diabetes ☐Neck Problems ☐HeartTrouble ☐Headaches ☐ Numbness ☐Asthma ☐Muscle Spasm ☐Digestive Disorders ☐ Nervousness ☐Sinus/Allergies ☐High Blood Pressure ☐Female Disorders ☐Cancer

Have you been seen by a doctor in the last year? ☐Yes ☐No

Describe:______________________________

____

Medications or Drugs you are taking______________________

____

____

INSURANCE

Who is responsible for this account?______________________

Relationship to Patient______________________

Insurance Co.______________________

Address______________________

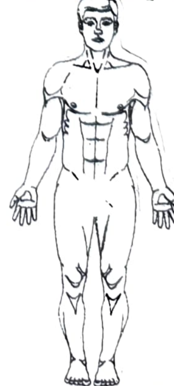
Group #______________ID______________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with the above named company, and all insurance benefits if any, otherwise payable to me for services rendered I authorize to be made directly to ACT Chiropractic. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________________ ______________

SIGNATURE Patient/Responsible Party **Date**



IF ACCIDENTIAL INJURY PLEASE COMPLETE THE INFORMATION REQUESTED ON THE REVERSE SIDE ☐