Chiropractic Family Wellness Center

1747 Smizer Station Rd. Unit 4 Fenton, MO 63026
Phone: 636-825-6555 Fax: 636-825-6546

Patient Name: _____ **Today's Date**: ___ / ___ / ___

Birthdate: ___ / ___ /___ **Age:** _____ **Gender:** F M

Address: _____**City**: _____**State:** _____

Zip Code:_____**Phone:** (_____)_____ **Cell:** (_____)_____

Emergency Contact: _____ **Phone:** (_____)_____

Occupation: _____ **Employer:**_____

Who may we thank for referring you to our office? _____

Who is your Primary Care Physician: _____**Phone:** (____)_____

Accident Information

Date of Accident: ___/___/___ **Time of Accident:**_____ am/pm □ Daylight □ Dawn □ Dusk □ Dark

Road conditions at the time of the accident: □ Wet □ Dry □ Snow □ Ice □Other:_____

Was the accident on the job? □ Yes □ No **Were you in a company vehicle?** □ Yes □ No

Where were you seated in the vehicle? □ Driver □ Passenger □ Rear-seat □ Other:_____

Were you aware of the approaching collision prior to impact, or did it catch you by surprise? □ Aware □ Surprised

Did you lose consciousness upon impact? □ Yes □ No

Did you experience a flash of light or explosion in your head? □ Yes □ No

Were the Police notified of the accident? □ Yes □ No **Is there a Police Report?** □ Yes □ No

Did you go to the hospital? □ Yes □ No **When?** □ Immediately □ ____hours later □ _____days later

Which hospital? _____

What did the hospital do for your injuries? (Collars, splints, x-rays, medication etc.) _____

What areas were x-rayed? _____**What was their Diagnosis?**_____

What did they recommend for follow-up care?_____

Was any other doctor consulted after your car accident? □ Yes □ No **If yes, please complete information below.**

Dr._____**Specialty?**_____**Date first seen:**___/___/___

Type of Treatment:_____**Frequency?**_____**Length:**_____

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Were you wearing a seatbelt? □ Yes □ No **If yes, did you receive any injury or bruise from the seat belt?** □Yes □No

Did you head hit the head rest during the accident? □ Yes □ No

If adjustable, was the position of the head rest altered? □ Yes □ No

Was the seat adjustment altered by the accident? □ Yes □ No **Was the seat broken by the accident?** □ Yes □ No

Did the air-bag deploy? □ Yes □ No **If yes, did it strike you?** □ Yes □ No **If yes, where?** _____

Which way was your head pointing at the point of impact? □ Straight □ Right □ Left **Body?** □ Straight □ Right □ Left

Where were your hands? □ One on the wheel □ Both on the wheel □ Not applicable

Were you wearing a hat or glasses at the time of impact? □ Yes □ No

If so, were they still on after the accident? □ Yes □ No

Please describe how the accident took place: _____
_____
_____
_____
_____

Your Car

List the year, make and model of the car you were in: Year: _____ Make: _____ Model:_____

Was your car stopped at the time of impact? □ Yes □ No **If yes, was the driver's foot on the brake** □ Yes □ No

If no, estimate the speed of the vehicle you were in: _____mph

If your vehicle was moving at the time of impact, was it: □ Slowing Down □ Gaining Speed □ Steady Speed

Other Car

List the year, make and model of the other car: Year: _____ Make: _____ Model:_____

Was the other car stopped at the time of impact? □ Yes □ No

Estimate the speed of the vehicle of the other car: _____mph

At the time of impact, was the other car: □ Slowing Down □ Gaining Speed □ Steady Speed

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Automobile Insurance Information

Driver of the automobile you were in: _____Name of their auto insurance:_____

Policy #:_____Claim #:_____

Auto Insurance Phone#:(____)_____Name of Insurance Adjustor:_____

Address: _____

Driver of other vehicle: _____Name of their auto insurance:_____

Policy #:_____Claim #:_____

Auto Insurance Phone#:(____)_____Name of Insurance Adjustor:_____

Address: _____

Have you retained an attorney?: □ Yes □ No **Name: _____Phone:** (____)_____

Verification form – PIP/Medpay

Does the Above-Referenced Policy contain Medpay or PIP benefits? □ Medpay □ PIP □ Neither

Was the coverage effective at the time of the accident? Yes No **If no, date coverage terminated** ___/___/___

Is there a claim for personal injury on file? Yes No **If yes, personal injury claim #:_____**

If the patient retains an attorney, will you still honor our assignment/lien and send payment to our office? Yes No

Maximum Dollar Amount of Medpay per Accident: $_____ **How much Met?** $_____

Name and address of where we should send claims:

Insurance Carrier: _____Adjustor:_____

Address:_____

Phone: (____)_____ **Fax**: (_____)_____

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Patient Condition

At the time of the accident, did you become or experience any of the following:

□ Confused □ Disoriented □ Light Headed □ Dizzy □ Nauseated □ Blurred Vision □ Ringing/Buzzing in Ears

□ Loss of Balance □ Other: _____

□ Headache	□ Dizziness	□ Light Sensitivity	□ Diarrhea	□ Head Feels Heavy
□ Loss of Memory	□ Clumsiness	□ Feet Cold	□ Stiff Neck	□ Tingling Arms/Hands
□ Sleeping Problems	□ Face Flushed	□ Hands Cold	□ Nausea	□ Back Pain
□ Buzzing Ears	□ Loss of Balance	□ Constipation	□ Nervousness	□ Ears Ring
□ Shortness of Breath	□ Fainting	□ Fever	□ Tension	□ Fatigue
□ Chest/Rib Pain	□ Arm/Hand Pain	□ Loss of Smell	□ Jaw Pain	□ Cold Sweats
□ Loss of Strength – Arms	□ Burning Muscle Pain	□ Loss of Strength - Legs	□ Difficulty Swallowing	□ Irritability
□ Sharp/Shooting Pain	□ Leg/Foot Pain	□ Numb Legs/Feet	□ Numb Arms/Hands	□ Tingling Legs/Feet
□ Neck Pain	Other:_____			

Do you still have any of these symptoms? Yes No **If yes, which ones?**_____

Check any symptoms you have had since the accident occurred:

Smoker? □ Former □ Never □ Current **Number of Packs per Day**: _____

Do you Drink Alcohol? □ Yes □ No **Quantity/Frequency**: _____

Caffeine Intake (Quantity/Frequency): _____

Medication List (Name of Medication, Dosage, Frequency):

_____ _____

_____ _____

_____ _____

WOMEN ONLY:

Are you pregnant or is there any possibility you may be pregnant? □ Yes □ No □ Uncertain

If checked YES, what is the estimated due date? ___/___/___

Are there any known pregnancy complications? _____

Please Mark on the Body Chart where your pain is located.

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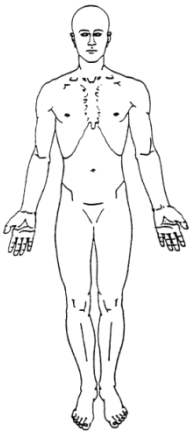
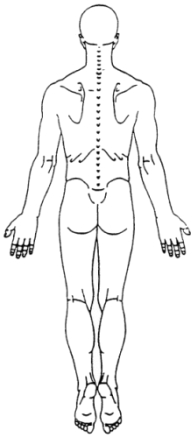




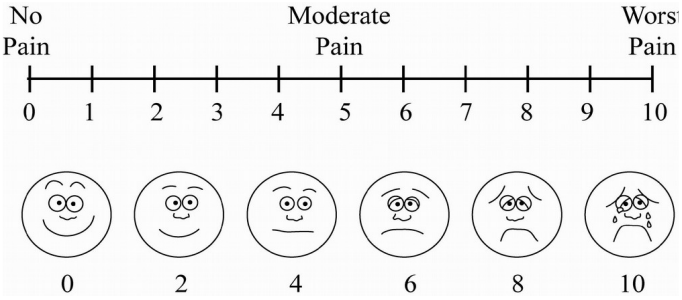
What Aggravates It? _____

_____

What Relieves It? _____

_____

Please rate the intensity of your pain (0 being no pain, 10 being extreme pain)



I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.

Patient's signature: _____ Date: ____/____/____

CONSENT TO TREAT A MINOR: I hereby authorize the doctor(s) at *Sunset Hills Family Chiropractic · Freedom Chiropractic* to administer care to my child.

Name of Child/Minor (Please Print)_____

Name of Parent/Guardian (Please Print) _____

Parent/Guardian Signature: _____Date: ____/____/____