

Is there anything you do that makes your condition worse? _____

How has this condition affected your life? _____

- A. Home life _____
- B. Occupational life _____
- C. Recreational life _____
- D. Rest and sleep life _____

Have you ever been in an automobile accident? Past year Past 5 years Over 5 years Never
ANY ACCIDENTS, FALLS, ETC. THAT MIGHT HAVE CAUSED YOUR PROBLEM? _____

ANY MEDICAL DIAGNOSIS FOR YOUR COMPLAINT _____

What surgery has been done? _____

Drugs you now take: Nerve Pills Pain Killers Muscle Relaxers Pep Pills Tranquilizers Insulin
 Birth Control Pills Other (please list) _____

ANY CHIROPRACTOR CONSULTED IN THE PAST? Name: _____

Dates consulted: _____ For what problem? _____

Fees are payable at the time x-rays, examinations, and treatments are received, unless other arrangements are made in advance. X-rays remain the property of this clinic.

Patient's signature: _____ Social Security No. _____ Date: _____

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE 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 foremen 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 Or did the other car strike yours? Yes No

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

- Headaches 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 too heavy Depression Fainting spell Constipation
- Back pain Pins and needles in arms Light bothers eyes Loss of smell Cold sweats
- Nervousness Pins and 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: _____

Name of your insurance company involved: _____

Name of insurance company of person responsible for injuries: _____

Have you been contacted by an insurance adjuster or company representative regarding this claim? Yes No

Do you have an attorney who has advised you in this case? Yes No Name: _____

Address of attorney: _____