PERSONAL INJURY QUESTIONNAIRE

Personal Information:

Name: _____ Home phone #:_____

Address: _____ Alt. phone #:_____

City/State/Zip: _____

Email address: _____

Date of birth: _____ Age: _____ Social Security #:_____

Insurance Information: (Vehicle You Were In)

Name of Company:_____ Phone #:_____

Address: _____

City/State/Zip: _____

Name on Policy (if other than self): _____

Policy #: _____ Claim #: _____

Accident Information:

Date of accident: _____ Time of Day_____ AM/PM

Were you ( ) Driver, ( ) Passenger, ( ) Front Seat, ( ) Back Seat.

Were you wearing a seatbelt? ( ) Yes ( ) No

Were you struck from ( ) Behind, ( ) Front, ( ) Left side, ( ) Right side?

Were you headed ( ) North, ( ) South, ( ) East, ( ) West?

Were the police notified? ( ) Yes ( ) No

Do you have an attorney? ( ) Yes ( ) No If yes, please provide attorney contact info:
_____
_____

Approximate speed of your vehicle: ____ mph. Other vehicle? ____ mph

Where did the accident occur? _____
_____
_____

In your own words, please describe the accident: _____

_____
_____
_____

Current Medical Complaints:

Prior to this accident, have you had any physical complaints similar to what you have now? ( ) Yes ( ) No
If yes, please describe: _____
_____

Were you hospitalized after the accident? ( ) Yes ( ) No
If yes, where? _____ Were X-Rays taken ( ) Yes ( ) No

Please read the following and check all that apply.
Medical complaints since the accident:

☐ Neck pain	☐ Numbness in fingers	☐ Leg pain
☐ Low Back Pain	☐ Numbness in toes	☐ Arm/Shoulder pain
☐ Upper Back Pain	☐ Pins & Needles Legs/Feet	☐ Ears Ringing
☐ Mid Back Pain	☐ Pins & Needles Arms/Hands	☐ Headache
☐ Dizziness	☐ Loss of memory	☐ Fainting
☐ Sleep problems	☐ Loss of taste or smell	☐ Loss of balance

Is pain worsened by any of the following:

☐ Sitting	☐ Walking	☐ Laying down	☐ Pulling
☐ Bending	☐ Lifting	☐ Standing	☐ Pushing

Does your pain radiate (travel)? _____

Is condition worse during certain times of the day? _____

What aggravates your condition/pain? _____

Is your pain getting progressively worse, better, or staying the same? _____

Any home remedies? _____

Is this condition interfering with Sleep? _____ Routine? _____ Other?_____

Please describe any other symptoms you have that are not listed here:
_____

_____

Current Health Habits:

Did/ do you…

Smoke/Use tobacco products?	Y	N
Drink alcohol/Take Drugs?	Y	N
Diet (do you eat healthy foods?)	Y	N
Drink water, how many glasses?	Y_____	N
Exercise regularly?	Y	N
Have teeth problems?	Y	N
Have eye problems?	Y	N
Have hearing problems?	Y	N
Have sleeping problems?	Y	N
Have occupational stress?	Y	N
Have physical stress?	Y	N
Have mental stress?	Y	N
Have hobbies/sports injuries?	Y	N

Sleeping posture: side – stomach – back

What is your height? _____ Weight? _____

Have you been under medical and/or drug care? _____

Do you have a primary care physician? Who? _____

What medications are you taking? _____
_____

What side effects have you experienced from the medications and/or surgery?
_____
_____

Do you take vitamins or supplements? _____
Please all vitamins and/or supplements:
_____
_____

Past Health Conditions And/Or Symptoms:

☐ Headaches	☐ Muscular In coordination	☐ Prostate Problems	☐ Depression
☐ Neck Pain	☐ Visual Disturbances	☐ Abnormal Weight	☐ Light Bothers Eyes
☐ Upper Back Pain	☐ Dizziness	Gain/Loss	☐ Loss of Memory
☐ Lower Back Pain	☐ Loss of Balance	☐ Loss of Appetite	☐ Ears Ring
☐ Shoulder Pain	☐ Nervousness	☐ Abdominal Pain	☐ Fever
☐ Irritability	☐ Elbow/Upper Arm Pain	☐ Ulcer	☐ Fainting
☐ Wrist pain	☐ High Blood Pressure	☐ Hepatitis	☐ Loss of taste
☐ Hand Pain	☐ Heart Attack	☐ Liver/Gall Bladder	☐ Diarrhea
☐ Chest Pains	☐ Hip/Upper Leg Pain	Disorder	☐ Feet Cold
☐ Stroke	☐ Knee/Lower Leg Pain	☐ Cancer	☐ Hands Cold
☐ Ankle/Foot Pain	☐ Angina	☐ Tumor	☐ Stomach Upset
☐ Jaw Pain	☐ Kidney Stones	☐ Asthma	☐ Constipation
☐ Kidney Disorders	☐ Joint Swelling/Stiffness	☐ Pins & Needles in legs	☐ Loss of Balance
☐ Arthritis	☐ Bladder Infection	☐ Pins & Needles in arms	☐ Buzzing
☐ Painful Urination	☐ Rheumatoid Arthritis	☐ Numbness in fingers	
General Fatigue	☐ Loss of bladder control	☐ Numbness in Toe	

Family History:

	Heart Disease	Arthritis	Cancer	Diabetes	Other
Fathers Side	☐	☐	☐	☐	☐
Mothers Side	☐	☐	☐	☐	☐

How old is, or was, your oldest living relative? _____years old

As a result of my chiropractic care, I would like to:

Please check all that apply

- ☐ Feel better quickly
- ☐ Have a healthier spine
- ☐ Have a healthier body by keeping my nervous system healthy
- ☐ Live a healthier lifestyle

_____ _____

Signature Date

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Print name)
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

Office Use Only
1
4-5
>5

Pain Drawing

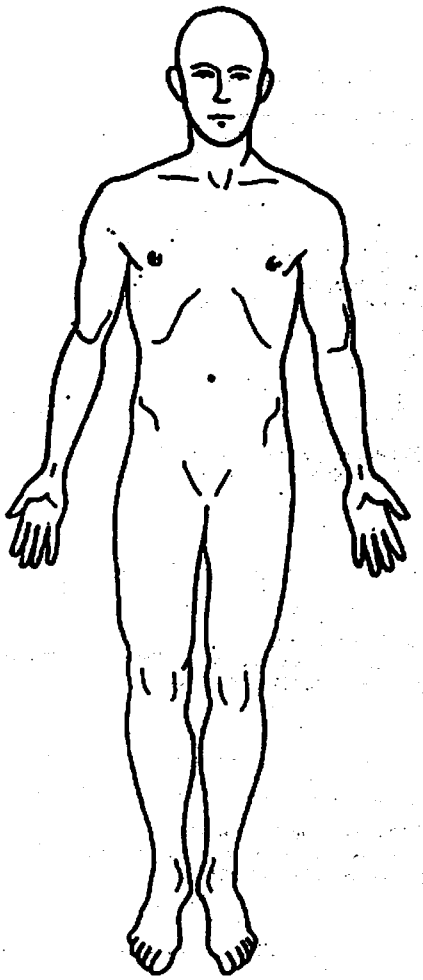
Name:_____ Date:_____

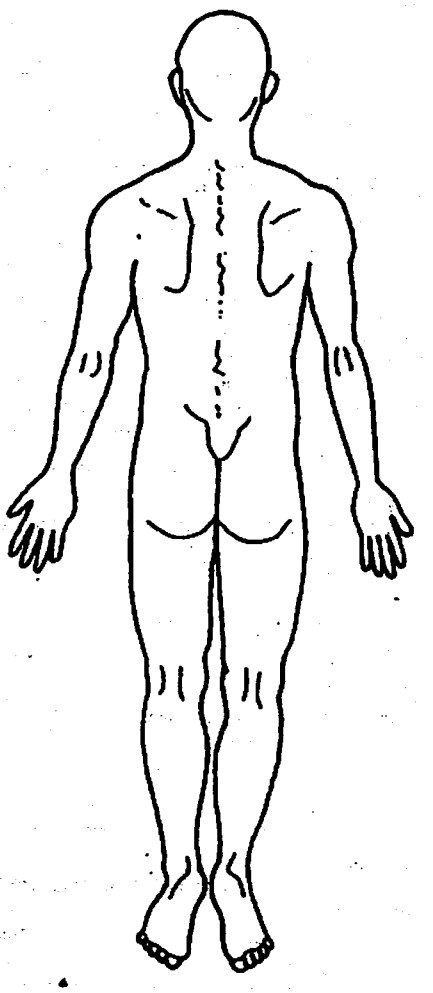
Date of Birth:_____ Examiner:_____

TELL US WHERE YOU HURT.

Please read carefully:
Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache > > > > > Numbness = = = = = = Pins & Needles o o o o
Burning x x x x Stabbing / / / / / Throbbing ~ ~ ~ ~ ~ ~ ~





Emil A. Tocci, D.C.

2421 Long Beach Road
Oceanside, NY 11572
(516) 766-1717

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLWDGEMENT

Patient Name: _____

Date of Birth: _____

I have received this practice's Notice of Private Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Private Practices, and to make changes regarding all protected health information resident at, or controlled by this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____

Relationship to patient (if other that self): _____

Date: _____