O A S I S C H I R O P R A C T I C E N T E R

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Oasis Chiropractic Injury/ Auto Accident/ Slip & Fall Form

First Name: ________________________________ Last Name:____

Title: (check one) □ Mr. □ Mrs. □ Ms. □ Miss □ Dr. □ Other Patient ID#: ________________________________

❑ Single ❑ Married ❑ Widowed ❑ Under 18 (Minor) ❑ Separated ❑ Divorced ❑ Domestic Partnership

Address: ___________________________________ Apt: _______City: ______________ State____ Zip: ___________

Date of Birth: ____/ ____/ ____ Age: ______ FOR WOMEN: Are you pregnant? □ Yes □ No Are you nursing? □ Yes □ No

Cell Phone: ___________________ Home Phone: □ n/a _______________________Work Phone: □ n/a ________________

Employment Status: Employed Unemployed F/T Student P/T Student Stay at home Mom Homemaker ❑ Other

Your Occupation ❑ n/a_________________________________Employer ❑ n/a __________________________________

In Case of Emergency, please notify ______________________________________ Phone ____________________________

How did you find out about Oasis: ❑ Internet /Google ❑Attorney ❑Employer ❑Friend ❑Other

***Date of injury/Auto Accident/Slip and fall:** _____/ _____/ _____ Time: _______ : _______ □ AM □ PM

Location of accident/injury/slip & fall: ____

Have you retained an attorney? □ Yes □ No (If you have your attorney's business card, please provide us with a copy to assure we have the proper information)

Name: ____

Phone: ____ Contact Person: ________________________________

Please describe in *detail* how the accident/injury/slip & fall happened:

____

____

____

Did you have any physical complaints BEFORE THIS accident/injury/slip & fall happened □ Yes □ No , if yes please explain

____

Do you have any congenital (from birth) factors which relate to this problem? □ Yes □ No, if yes please explain:

____

Have you noticed any activity restrictions as a result of this accident/injury/slip & fall happened □ Yes □ No , if yes please explain

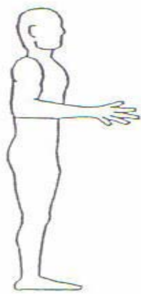
____

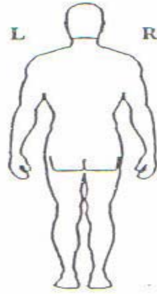
OASIS CHIROPRACTIC CENTER
DR. MYLES STARKMAN
799 BRICKELL PLAZA #803
MIAMI, FL 33131

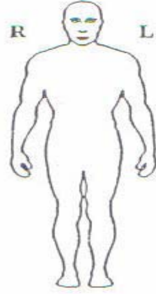
Oasis Chiropractic Injury/ Auto Accident/ Slip & Fall Form

Your Name: ____

Areas of Complaint
Place **X's or Circles** on the areas where you have pain and **draw lines** to where it radiates:







Check symptoms you have noticed since the injury/ accident /slip & fall (mark all that apply)

□ Headaches	□ Irritability	□ Numbness in Toes	□ Digestive Problems	□ Face Flushed
□ Neck Pain	□ Chest Pain	□ Shortness of Breath	□ Shoulder Pain	□ Buzzing in ears
□ Stiff Neck	□ Dizziness/Loss of balance	□ Fatigue	□ Elbow Pain	□ Fainting
□ Back Pain	□ Head Seems to Heavy	□ Depression	□ Wrist/Hand Pain	□ Loss of Taste
□ Sore throat	□ Pins & Needles in Arms	□ Lights bother eyes	□ Upper Back Pain	□ Loss of Smell
□ Nervousness	□ Pins & Needles in Legs	□ Loss of Memory	□ Ears Ringing	□ Diarrhea
□ Tension	□ Numbness in Fingers	□ Ankle/Foot Pain	□ Heart Burn	□ Cold Sweats
□ Feet Cold	□ Hands Cold	□ Stomach Upset	□ Constipation	□ Fever

□ Bruises, cuts, scrapes and/ or scars if so please explain:
____

□Other: ____

Is your condition getting worse? □ Yes □ No   Is it Constant? □ Yes □ No   Comes and Goes? □ Yes □ No

Have you already seen other doctors for this/these condition(s)? □ Yes □ No

Please list other doctors seen and approximate date seen (including primary care physician):

Doctor / Facility	Approximate Date Seen
1. ______________________________	1. ____________________
2. ______________________________	2. ____________________

Have you ever been involved in an accident/injury/slip & fall prior to this one? □ Yes □ No, If yes what type was it?

□ Auto □ Work □ Slip n Fall □ Leisure □ Sports □ Other ____________ When?: ____________________

Briefly Explain: ____

Are you presently taking any medication? □ Yes □ No Please List: ______________________________

*Signature of Patient, Parent, Guardian or Personal Representative ______________________________

O A S I S   C H I R O P R A C T I C   C E N T E R
D R .   M Y L E S   S T A R K M A N
7 9 9   B R I C K E L L   P L A Z A   # 8 0 3
M I A M I ,   F L   3 3 1 3 1

Oasis Chiropractic Injury/ Auto Accident/ Slip & Fall Form

Have you lost time from work? □ Yes □ No If yes how many days: ______

Did you go to the Emergency Room? □ Yes □ No If yes, when? ____

Name of the Hospital Emergency Room: ❑ n/a ____

Where you admitted? □ Yes □ No □ ❑ n/a If hospitalized, date admitted __________________ date discharged _________________

List any medications that you were given: ____

Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray) etc. regarding this injury.
If yes, please list: ❑ n/a

	Body part	Date
MRI	____	______/_____/_____
CT/CAT Scan	_________________________________	_____/______/_____
X-Ray	______________________________________	_____/______/_____

Do you have any future appointments with any doctor regarding your injuries? □ Yes □ No

If yes, when and with whom? ____

Do you have Auto Insurance? □ Yes □ No
Auto Insurance Company Name: ____
(Only for auto accident patients)
Please provide staff with a copy of your auto insurance card

Do you have secondary Insurance? □ Yes □ No
Name of Health Insurance Company: ______________________________________ Policy Number: ___________________________
Please provide staff with a copy of your health insurance card

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child ever has a change in health.

I certify that I, and/or my dependent(s) have insurance with the aforementioned Insurance Companies and assign directly to Oasis Chiropractic Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Oasis Chiropractic Center may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my currant treatment plan is completed or one year from the date signed below.

*Signature of Patient, Parent, Guardian or Personal Representative ____

Please PRINT name of Patient, Parent, Guardian or Personal Representative ____

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Oasis Chiropractic Auto Accident Questionnaire

*If your injury is **NOT** due to an Automobile Collision, please skip this potion of the form*
Please provide staff with a copy of your automobile insurance card and a copy of the police report, if it is available.

Your Name: ____

Insured's/ Policy Holder Name(s): ____, _____________________________________

Have you contacted your auto insurance company? □ Yes □ No ❑ n/a (LOP)

* *Adjustor's Name:* __________________________________*Phone Number:* _________________________________ *ext:* ________

Fax Phone Number: ________________________________

Claim Number: ____ *Policy Number:* _____________________________________

Were you the □ Driver □ Front Passenger □ Back Left Side Passenger □ Back Right Side Passenger □ Pedestrian □ Other ___________

How many people were in the vehicle? ______

Were you wearing a seatbelt at the time of the accident? □ Yes □ No

Was your vehicle stopped?? □ Yes □ No If no, approximate speed: ________ mph

Was the other vehicle stopped? □ Yes □ No If no, approximate speed: _________mph

At impact, was your body straight in your seat? □ Yes □ No If no, turned to the (□ Left / □ Right) □ Other: _______________________

At impact, were you looking straight ahead? □ Yes □ No If no, was your head turned to the (□ Left /□ Right / □ Up/Down)

Were you aware that you were about to be hit? □ Yes □ No

Were you struck from: □ Behind □ Front □ Left side □ Right side

Did your (chest / head) hit the steering wheel? □ Yes □ No

Did an airbag deploy? □ Yes □ No

Did your head hit the (Windshield / Side Window)? □ Yes □ No

Did your knees hit the dashboard? □ Yes □ No

Did you lose consciousness? □ Yes □ No If yes, how long:_______________ Did the police arrive at the scene □ Yes □ No

Did you strike the other vehicle? □ Yes □ No Did the other vehicle strike you? □ Yes □ No

Were traffic citations issued to: □ You □ Driver of your car □ Driver of other car □ None

Your car was heading: □ North □ South □ East □ West on ______________ (street or highway)

The other car was heading: □ North □ South □ East □ West on ______________ (street or highway)

*Signature of Patient, Parent, Guardian or Personal Representative ____

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Oasis Chiropractic Auto Accident DIAGRAM

Patient Name: ___________________________________

Example

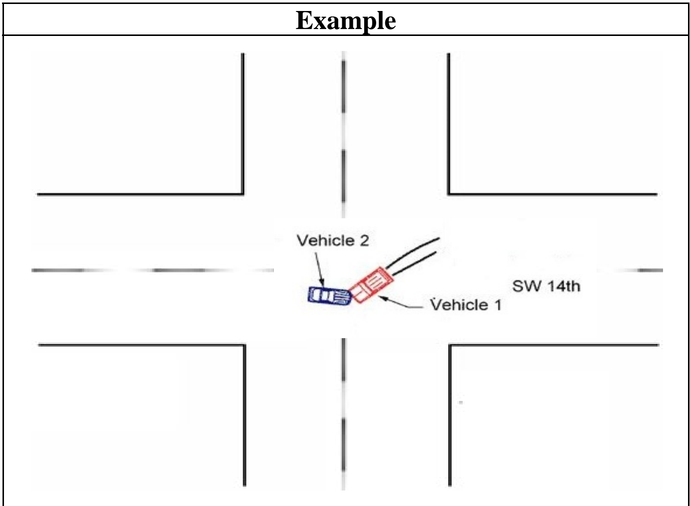
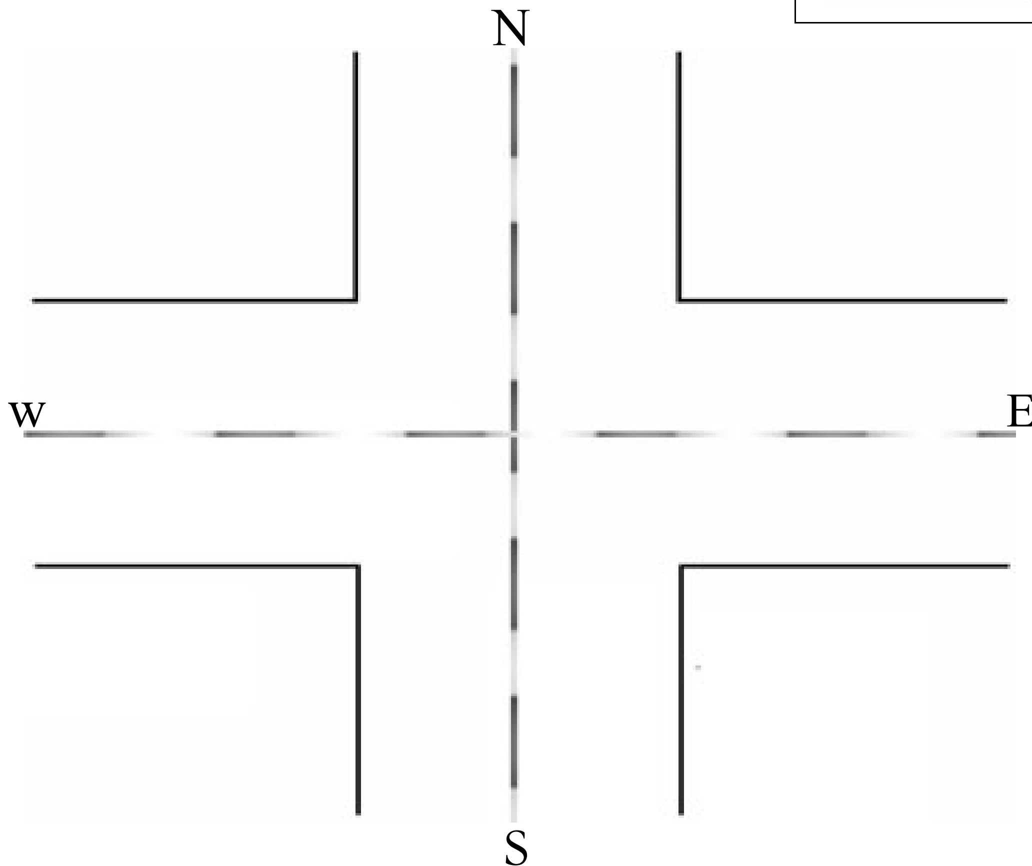
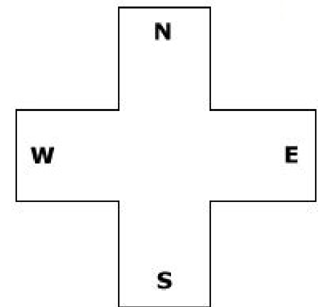


DIAGRAM OF ACCIDENT
PLEASE DRAW DIAGRAM IN SPACE BELOW
1. Number your vehicle as #1, other vehicle(s) as #2, #3, etc.
2. Show pedestrian by: **O**
Example:

3. Show direction of travel by an arrow.
4. Show which parts of cars came together.
5. Give names or numbers of streets or highways.
6. Show traffic signs and signals.





*Signature of Patient, Parent, Guardian or Personal Representative ___________________________________

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PHONE: 305-374-5866

Oasis Chiropractic Slip and Fall Questionnaire

*If your injury is **NOT** due to a Slip-n-Fall, please skip this potion of the form*

Your Name: ____

Were you carrying anything in your hands at the time of your fall? ____________________

How did you land? ____

What caused the obstacle or condition (eg. A water leak, broken bottle, raised cement, etc.)? ________

____

Did anything fall on you? □ Yes □ No ,if yes what? ____________________

Did you hit your face or head? □ Yes □ No Did your feet go out from underneath you? □ Yes □ No

Do you have any (cuts / bruises) □ Yes □ No If yes, where: ____________________

Did you lose consciousness? □ Yes □ No If yes, how long: ____________________

Were the police notified □ Yes □ No

*Signature of Patient, Parent, Guardian or Personal Representative ____________________