PORTER FAMILY CHIROPRACTIC CENTER

Your Family and Your Health are in Great Hands!

Dear New Patient:

On behalf of all of us at Porter Family Chiropractic Center we regret that you have been involved in an accident; however, we would like to take a moment to welcome you to our office and thank you for the opportunity to serve you and your chiropractic needs.

To give you a little more information about what to expect today, you will have an examination/evaluation will be performed and x-rays will be taken. For today's visit, you can expect the entire fee to range from $125--$550, which includes the exam/evaluation, all x-rays taken, thermal scan, and your chiropractic adjustment.

Included in the paperwork given to you, a payment plan option form will help you to choose how your financial account will be handled for your upcoming care. Please be assured that every attempt will be made to contact the insurance company and/or your attorney during this visit today to obtain the necessary information for your claim. Depending on the information we receive, a payment of $25 may be required.

If you should have any questions concerning your options, please do not hesitate to ask our staff. We will be glad to help! To make your payments as convenient as possible, we accept cash, check, or credit/debit cards (Visa, MasterCard, Discover, AMEX). Once again, welcome to our office and to our growing family of chiropractic patients. We thank you for choosing our office for your health care.

Helping you to build better health,

Dr. Debby Porter & Dr. Janet Lewis
and Staff

_____ _____

Signature Date

2655 Dallas Highway, Suite 110 Marietta, GA 30064
Phone: 770-427-1889 Fax: 770-427-7513
Web-site: porterfamilychiropractic.com

PORTER FAMILY CHIROPRACTIC CENTER

2655 Dallas Hwy. Suite 110
Marietta, GA 30064
(770)427-1889

Name: _____ Date: _____
First Middle Last

Address: _____ City: _____ State & Zip: _____

Date of Birth: _____/_____/_____ Male / Female Social Security #: _____-____-_____

Circle: Married Single Widowed Divorced Partner Partner/Spouse's Name: _____

Home #: ( ) _____ Work #: ( ) _____

May we contact you at work? YES NO Cell / Pager #: ( ) _____

Email address: _____ @ _____ . _____ (for official office use only)

Occupation: _____ Employer's Name: _____

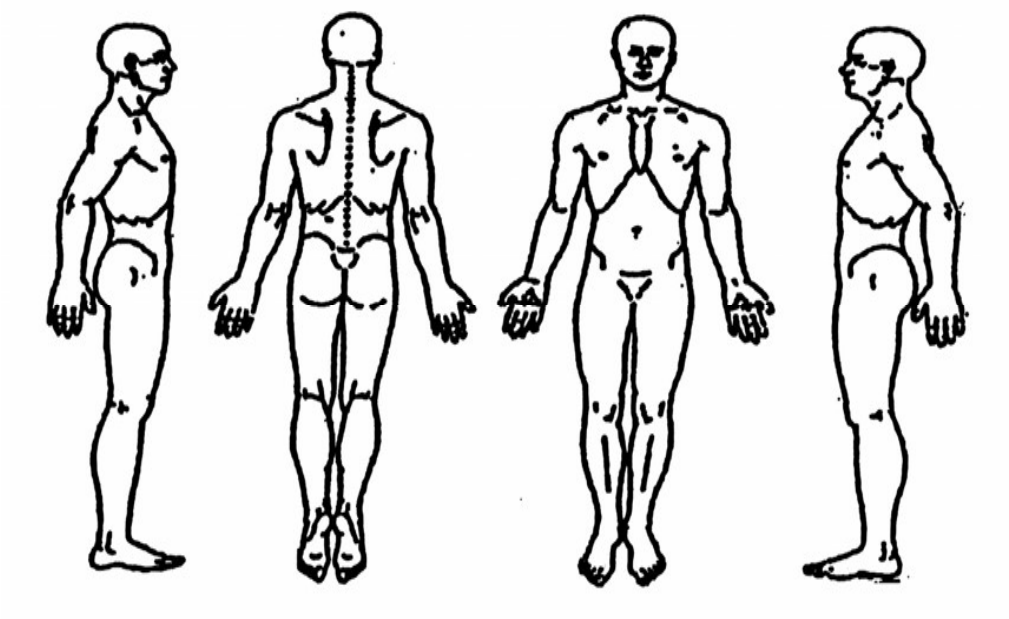
Address: _____ City / State / Zip: _____

Non Family Emergency Contact: _____/_____(____)_____
Name Relationship Phone

Who referred you to us? _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation □ Other _____

2. Indicate on the drawings below ALL areas of concern and # in order of priority!!



3. How often do you experience your symptoms?

Area #1
□ Constantly (76-100% of the time)
□ Frequently (51-75% of the time)
□ Occasionally (26-50% of the time)
□ Intermittently (1-25% of the time)

Area #2
□ Constantly (76-100% of the time)
□ Frequently (51-75% of the time)
□ Occasionally (26-50% of the time)
□ Intermittently (1-25% of the time)

Area #3
□ Constantly (76-100% of the time)
□ Frequently (51-75% of the time)
□ Occasionally (26-50% of the time)
□ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

Area #1
□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

Area #2
□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

Area #3
□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time?

Area #1
□ Getting Worse
□ Not Changing
□ Getting Better

Area #2
□ Getting Worse
□ Not Changing
□ Getting Better

Area #3
□ Getting Worse
□ Not Changing
□ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

Area #1 _____ Area #2 _____ Area #3 _____

7. How much has the problem interfered with your work?

Area #1
□ Not at all □ A little bit
□ Moderately □ Quite a bit
□ Extremely

Area #2
□ Not at all □ A little bit
□ Moderately □ Quite a bit
□ Extremely

Area #3
□ Not at all □ A little bit
□ Moderately □ Quite a bit
□ Extremely

8. How much has the problem interfered with your active daily living?

Area #1
□ Not at all □ A little bit
□ Moderately □ Quite a bit
□ Extremely

Area#2
□ Not at all □ A little bit
□ Moderately □ Quite a bit
□ Extremely

Area #3
□ Not at all □ A little bit
□ Moderately □ Quite a bit
□ Extremely

9. How long have you had this problem? Area #1_____ Area #2_____ Area #3_____

10. How do you think your problem began?

Area #1_____

Area #2_____

Area #3_____

12. What aggravates your problem?

Area #1 _____

Area #2 _____

Area #3 _____

13. What makes your problem feel better?

Area #1_____

Area #2_____

Area #3_____

14. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

15. What concerns you the most about your problem (Please Pick Only One)?

□ Could be Serious □ Not Going Away □ Getting Worse □ Affecting Work □ Affecting Sleep
□ Affecting Mental Outlook □ Affecting Relationships □ Affecting Leisure □ Other: _____

16. What is your: Height_____ Weight _____

17. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

18. What type of exercise do you do? _____

19. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

21. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the last 6 months but are not currently experiencing. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependence
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□	Ankle/Foot Pain	□	□	Loss of Appetite	**For Females Only**		
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Hormonal Replacement
□	□	Arthritis	□	□	Hepatitis	□	□	Pregnancy
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder			
□	□	Cancer	□	□	General Fatigue			
□	□	Tumor	□	□	Muscular Incoordination			
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis	□	□	Dizziness			
□	□	Other:_____						

22. List any prescription medications or over-the-counter medications you are currently taking:

_____

_____

23. List any nutritional supplements you are currently taking:

_____

_____

24. List all surgical procedures you have had:

_____

_____

25. What activities does your job require?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day
□ **Drives:**	□ Most of the day	□ Half of the day	□ A little of the day
□ **Walk**	□ Most of the day	□ Half of the day	□ A little of the day
□ **Other:**	□ Manual Labor	□ Reads a lot	□Travels a lot

26. What activities do you do outside of work? _____

27. Have you ever been hospitalized? □ No □ Yes

If yes, why_____

28. Have you seen a chiropractor before? □ No □ Yes

If yes, who: _____how long ago: _____ results were: □ Good □ Mixed □ Bad

29. Have you had significant physical trauma in the past? □ No □ Yes

If yes, please explain (include type of trauma and year):_____

_____

_____

30. Anything else pertinent to your visit today? _____

I authorize this office to release any information requested by my insurance company or other health care individuals to document my claim for benefits or assist in further health care purposes. The above information was completed correctly to the best of my knowledge and I understand that it is my responsibility to inform this office of any changes in my health status or financial status.

Patient (or Guardian) Signature_____ **Date** _____

Consent to evaluate and adjust a minor child

I,_____ , being the parent or legal guardian of
have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____

Signature *Date*

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that an x-ray can be hazardous to an unborn child.
Date of last menstrual period: _____

_____ _____

Signature *Date*

Consent for Treatment

I, the undersigned, herby authorize the Doctors of Porter Family Chiropractic and whomever they may designate as their assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary.

I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. **However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.**

Patient's Signature_____ Date____/____/____ Witness_____

HIPPA INFORMATION

DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

1. I give permission to Porter Family Chiropractic use my address, phone number and clinical records to contact me with birthday cards, newsletters, patient letters, thank-you cards, first adjustment calls, testimonials and information about treatment alternatives or other health related information.
2. By signing this form you are giving Porter Family Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Porter Family Chiropractic. The written notice must contain the following information:

Your Name, Social Security Number and Date of Birth; A Clear Statement of Your Intent to Revoke This AUTHORIZATION; The Date of Your Request and Your Signature.

I have read and agree to the financial policy and Hippa privacy policy set above. Furthermore should I for any reason, discontinue care, I understand that the entire balance for professional services rendered to date will be due within 30 days. I agree that you may release my information to my insurance agent / adjuster or their agents regarding my care in this office. I also understand that the records including x-rays are a permanent record and are the property of Porter Family Chiropractic. Copies are available at a nominal charge. A copy of this agreement will serve as the original. This AUTHORIZATION is requested by Porter Family Chiropractic for its own use or disclosure of PHI. (Minimum necessary standards apply.) You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Porter Family Chiropractic will not refuse to provide treatment.

_____ _____

Name (printed) Date

_____ _____

Signature of Patient / Guardian Witness

Your Family and Your Health are in Great Hands!

Porter Family Chiropractic Center
OFFICE POLICIES AND PROCEDURES

Please check next to each item and sign/date the back of this sheet.

_____ **1. Chiropractic Results:** We are very result-focused, however there are many factors which effect how quickly your body responds to our care. Some are: your age, occupation, how long you've had your vertebral subluxations (pinched nerves), and the number of subluxations present in your spine. Your body has the incredible ability to heal itself from within! The Doctor will consider these factors before making a recommended treatment plan. Our goal is to get you to a level of health where Wellness Care becomes the desired result-- adding Years to your Life, and Life to your Years!

_____ **2. Symptoms:** It is important to understand the differences between your symptoms and their causes. A symptom is an outward pain/discomfort created by your body to communicate that something is wrong on the inside. The cause of the pain/symptom may be a result of something that happened long ago, never surfacing until now. As your spine is corrected you will have good and bad days. Don't get caught up in this roller coaster; just know that it is ***normal.*** You will get the best results if you understand that this is a process that takes time designed to get you functioning at your peak level and on the road to wellness. Stay focused on the outcome and enjoy the journey towards a healthier you!

_____ **3. Appointments:** The next two appointments after today are about giving you as much information about you and your condition and will be of upmost importance. The first, the doctor will present the findings as to the cause of your problems, and the next will be to give you more information on how the body is designed to work, called the New Patient Orientation. Your adjustments will not be scheduled at specific times, however you will be scheduled to be here on specific days of the week. A certain number of adjustments in a given time period is necessary to get you the best results from re-training your nerve and muscle memory. Maintaining your Doctor-recommended treatment plan will offer you the best opportunity to heal and build wellness, preventing regression in your expected results. While we can't predict the exact number of adjustments you will need, we do know that ***consistency creates the best results***.

_____ **4. Daily Visit Procedure:** When you arrive please sign in and take a seat in the reception room until the Front Desk Chiropractic Assistant directs you to an adjusting room. When in the room, close the door, ***lie down on your stomach and relax*** to aid in the success and comfort of your adjustments. Once the Doctor learns your spine your adjustments will be focused and last only a few minutes. When leaving the room, please **leave the door OPEN for the next patient to enter**.

Patient: _____ Date: _____

PORTER FAMILY CHIROPRACTIC CENTER

Our *ultimate goal* for you is to help your entire body and its organs to perform at their highest level possible helping you to attain and then maintain maximum *health*. In order for us to further evaluate your areas of malfunctioning health conditions, please circle the answers to all the questions below. Please indicate if the problem pertains to you, your spouse, or another family member (mom, dad, child).

Name _____ Date _____

Occupation _____ Age _____

	You	Spouse	Family	Parent (M/F)
1. Have you ever had any problems with your Heart? High or Low Blood Pressure, High or Low Pulse Rate, Placquing of Arteries, Pains in Chest, Heart Attack(s), or other. _____	_____	_____	_____	_____
2. Have you ever had any problems with your Lungs? Difficulty in Breathing, Asthma, Shortness of Breath, Bronchitis, Pneumonia or Other. _____	_____	_____	_____	_____
3. Have you ever had any problems with your Stomach? Indigestion, Heartburn, Upset stomach, Ulcers, Hiatal Hernia, Reflux, or Other. _____	_____	_____	_____	_____
4. Have you ever had any problems with your Digestive System? Constipation, Diarrhea, Gas, Bloating, Irritable Bowel Syndrome, or Other. _____	_____	_____	_____	_____
5. Have you ever had any problems in your Reproductive System? Women: PMS, Irregular Cycles, Menopause Infertility, Cysts of Ovaries or Uterus Precancerous Conditions, or Other. _____	_____	_____	_____	_____
Men: Prostate Enlargement, Difficulty in Starting Urination, Infertility, or Other. _____	_____	_____	_____	_____
6. Do you "Catch" Bugs/Viruses Easily (colds, flu, etc.)?	_____	_____	_____	_____

7. **Have you ever had any problems with your Ears?**

   Earaches, Ear Infections, Tubes in Ears or Scheduled

   Surgery for Tubes, Ringing in Ears, or Other. _____

   _____ _____ _____ _____ _____

8. **Have you ever had any problems with?**

   Headaches, Migraines, Sinus Problems, Nose problems,

   Eye problems, Allergies, Sleep problems or Other. _____ _____ _____ _____ _____

   You Spouse Family Parent (M/F)

9. **Have you ever had any problems with your Kidneys/Bladder/Liver**
   Difficulty or pain upon urination, Leaky Bladder, Blood

   Disorder(s), Kidney stones, Gallstones, Bladder infections,

   or Other. _____ _____ _____ _____ _____

10. **Have you ever had any problems with your Pancreas?**
    High or Low Blood Sugar, Taking Insulin or other

    Medications, or Other. _____ _____ _____ _____ _____

11. **Have you ever had any problems with Hormonal Imbalances?**
    Anxiety, Depression, Change of Life Hormonal problems,

    Thyroid problems, ADD/ADHD or Other._____ _____ _____ _____
_____

12. **Do you regularly take aspirin or other over the counter drugs?** _____ _____ _____ _____

13. **Have you ever smoked?** _____ _____ _____ _____
    Do you smoke more than 10 cigarettes a day? _____ _____ _____ _____

14. **Have you ever been diagnosed with any of the following: cancer, fibromyalgia, chronic fatigue, multiple sclerosis, lupus or other, give details.**

    _____

    _____

15. **Do you have any other health problems or pain not mentioned above? Please describe where and how long you have experienced the problem(s).**

    _____

    _____

16. **When you were born, were you delivered natural; vaginal with anesthesia, forceps, or vacuum extraction; or by c-section?** _____

17. **On a scale of 1-10, (1 being least important, and 10 being the most important)**

Describe the priority of your health. Your answer is: _____

18. Choose one of the following which best describes your health goal(s).

_____ Only interested in getting out of pain.

_____ To take my health beyond the absence of pain, and to regain my health even though it may take more time and effort.

_____ Once I attain my best health possible, I am interested in maintaining my new wellness state for as long as possible during my lifetime.

19. I understand that my body is the ONLY one I'll ever have, therefore it makes sense to want to make it the "BEST" possible. Yes No

20. I also understand that this is the ONLY *LIFE* I will ever enjoy, therefore I want to Learn as much as possible on how I can take care of it during the years to come.

Yes No

21. Does it make sense to you that when you improve your health, it will in turn improve the QUALITY **OF YOUR** *LIFE?* **Yes No**

Porter Family Chiropractic Center
2655 Dallas Hwy. Ste. 110 Marietta, GA 30064
Phone: 770.427.1889 Fax: 770.427.7513

Date: _____

ATTORNEY, DOCTOR, CLIENT AGREEMENT FOR CHIROPRACTIC CARE TO BE RENDERED

I do hereby authorize Dr. Porter and/or Dr. Lewis to furnish you, my attorney, with a full report of her diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved on _____.

I hereby authorize and direct my attorney to pay directly to said doctor such sums as may be due and owing her for chiropractic services rendered me both by reason of this accident and by reason of any other bills that are due to her office and to withhold such sums from my settlement, judgment, or verdict as may be necessary to fully compensate said doctor for services.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney shall honor this agreement as inherent to the settlement and enforceable upon the case as if it were executed by him/her.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by her for services rendered me and that this agreement is made in consideration of said doctor agreeing to await payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

Please acknowledge and accept this letter by signing below and returning it to the front desk. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interests the doctor will not await payment, but may declare the entire balance due and payable at any time.

_____ _____
Client/Patient Name (Please Print) Client/Patient Signature

The undersigned being my attorney on record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to fully protect said doctor above named in consideration for awaiting payment for services rendered.

_____ _____
Date Attorney Signature

_____ _____
Date Doctor Signature

Please write out the following letter, in your own handwriting, with the stationery that has been provided. Write only what pertains to your situation concerning the appropriate Doctors' name and if children were involved in the accident with you.

PLEASE BE SURE TO INCLUDE YOUR SIGNATURE AND TODAY'S DATE

To Whom it May Concern,

This letter is to serve as a written request and giving my express permission to have any and all payments sent directly to Dr. Debra Porter at the above address for the services and care received for my recent accident case.

I realize that an insurance company and/or an attorney, may send payments to Porter Family Chiropractic Center on my behalf for my accident care; however, I acknowledge that my bills and balances are ultimately and fully my responsibility.

If any payments are sent directly to me for this accident care, I agree to pay Porter Family Chiropractic, in full, within 30 days.

(*if applicable please include the following)*

I extend this request to include my child/children, (*please write out their names*), who also received care for this accident.

(Sign and Date)

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PORTER FAMILY CHIROPRACTIC CENTER

2655 Dallas Hwy. Suite 110, Marietta, Georgia 30064
Ph. (770) 427-1889 Fax (770) 427-7513

Since you have been involved in an automobile accident, please indicate below the financial arrangement for your care.

1. Auto Medical Coverage plan: No co-payments will be necessary if your car insurance policy includes medical payments (med-pay), therefore all services will be billed directly to your insurance company. If your car insurance should have a dollar amount limitation, the remaining balance will be your responsibility.

2. Waiting on Settlement plan: A $25 co-payment will be required on each visit if you are choosing to wait on a settlement from the at-fault's insurance company and/or if you choose to work with an attorney that our office has not had a working relationship with in the past*. This choice is extending credit to you for the care received and will help pay down the balance a little at a time.

   *If you choose to work with one of the attorneys on our list, you will not be responsible for any co-payments while receiving care caused by the accident. Our office will allow payment to be made once the case is settled.

Please be advised that the choice you make is totally up to you. We will be happy to provide a list of attorneys who have worked with our patients in the past, and we are familiar with their business ethics. You are welcome to work with anyone you wish; however, a payment will be necessary with each visit to help your account to be paid during the time you are receiving care. At the time of settlement, the at-fault's insurance company or attorney will request a balance due on your account. We will submit the full amount, not including any payments you have made. When a settlement has been reached you will pay only the balance on your account.

Please circle your choice above. I have read and agree to the selected statements above and will abide by the payment arrangement that is required according to the plan I have chosen.

Signed: _____ Date: _____

Personal Injury Questionnaire

Has your Auto Insurance company been notified of this accident?

Full Name _____ Phone ( ) _____ DATE _____

Your Insurance Co. _____ Agent's Name _____

Phone # (___)_____

Policy # _____ Claim # _____

Name on Policy (if other than self) _____

Responsible Party's Name _____ Ins. Co _____

Ph # _____

Address _____ City _____ State _____

Zip _____

Policy Holder's Name (if other than above) _____

Policy # _____

Who will be responsible for today's visit/charges? _____

Emergency Contact _____ Phone # _____
Relation _____

ATTORNEY

Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Were there any witnesses? □ Yes □ No Names _____

Phone No(s). _____

DETAILS OF ACCIDENT : Date of Accident: _____

Were you? □ Driver □ Passenger □ Front Seat □ Back Seat

Number of people in your vehicle: _____ Were you wearing seatbelts? □ Yes □ No

Direction Headed: □N □S □E □W

Which direction was other vehicle headed? □N □S □E □W Were you struck from? □ Behind □ Front □ Left side □ Right side

Name of Street/ Intersection: _____City_____

County _____State_____

Did you know the accident was about to happen? □ Yes □ No

What direction were you looking? _____

Approximate speed of your car _____mph Other car _____ mph

Amount of damage to car $ _____

Were you knocked unconscious? □ Yes □ No If yes, how long? _____ Were police notified? □ Yes □ No

Citation (s) issued? □Yes □No To Whom? _____

In your own words, please describe the accident:

_____

_____

_____

_____

Did you have any physical complaints BEFORE THE ACCIDENT? □ Yes □ No If yes, describe in detail:

_____

_____

_____

Please describe how you felt:

During the Accident:

Immediately after the accident:

Later that day:

The next day:

_____

What are your present complaints?

_____

Where were you taken after the accident?

_____

Have you been treated by another doctor since the accident? □ Yes □ No If yes, please list the doctor's name and address:

What type of treatment did you receive?

Since this injury occurred, are your symptoms: □ Improving □ Getting Worse □ Same

CHECK ADDITIONAL SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

□ Neck stiff	□ Loss of hearing	□ Pins and needles in toes	□ Diarrhea
□ Head seem too heavy	□ Ringing in ears	□ Numbness in Fingers	□ Constipation
□ Light bother eyes	□ Buzzing in ears	□ Numbness in Toes	□ Sleeping problems
□ Memory loss	□ Loss of balance	□ Cold hands	□ Nervousness
□ Face flushed	□ Fainting	□ Cold Feet	□ Tension
□ Loss of taste	□ Shortness of breath	□ Cold Sweats	□ Irritability
□ Loss of smell	□ Pins and needles in arms	□ Upset stomach	□ Fever

□ Other _____

Have you lost time from work as a result of this accident? □ Yes □ No If yes, please complete these questions:
Last Day Worked _____ Type of Employment _____ Are you being compensated for time lost from work? Yes / No

If yes, please state type of compensation you are receiving.

_____

Do you notice any activity restrictions as a result of this injury? □ Yes □ No If yes, please describe in detail:

Other pertinent information – relating to the accident/injuries:

Date_____ Patient Signature_____