Patient Introduction Card

Today's Date _____ Account #_____

Full Legal Name _____ Prefer To Be Called_____

Home Address_____ Occupation_____

City_____ State_____ Zip_____ Employer_____

Home Phone_____ Name of Insurance Co_____

Cell Phone_____ Policy Holder Name _____

Work Phone_____ Policy Holder Date of Birth _____

Email_____ Primary Care Doctor_____

Date of Birth_____ Age_____ Previous Chiropractic Care? ☐ YES ☐ NO

☐ Married ☐ Single ☐ Other_____ Major Complaint Today_____

Preferred method of contact for appointment reminders ☐ Text ☐ Email ☐ Either is fine

Who (or what source) referred you to our office? _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Automobile Accident Questionnaire

Patient Name: _____ Date: _____

Date of the accident: _____ You were: ☐ Driver ☐ Front Seat ☐ Passenger Back Seat

You : ☐ Struck another vehicle ☐ Struck by another vehicle ☐ Was struck by and caused to strike another vehicle

Where was the impact to your vehicle? ☐ Behind ☐ Front ☐ Left Side ☐ Right Side

Were you wearing a seatbelt? ☐ Yes ☐ No Did you see it coming (braced for impact)? ☐ Yes ☐ No

At the time of impact your vehicle was: ☐ Stopped ☐ In motion Was the car totaled? ☐ Yes ☐ No

Was there anyone else in your vehicle? ☐ Yes ☐ No Was anyone else injured? ☐ Yes ☐ No

At the time of impact you were: ☐ Head faced forward ☐ Head turned left ☐ Head turned right

Did any part of your body hit any part of the car during impact? ☐ Yes ☐ No

If so which body part: _____ What part of the car did it hit? _____

Did you feel pain immediately after the impact? ☐ Yes ☐ No If so, where was your pain: _____

Were you taken to the hospital: ☐ Yes ☐ No Hospital: _____

Were any X-Rays taken? ☐ Yes ☐ No Treatment received: _____

Have you missed any work as a result of the accident? ☐ Yes ☐ No If so, number of days missed? _____

Were you working when this accident happened? ☐ Yes ☐ No If so, has a worker's Comp claim been filed? ☐ Yes ☐ No

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Have you retained an attorney? ☐ Yes ☐ No ☐ Not yet

If an attorney has been retained, please provide us with their name, full address and phone number:

_____

STATE where the accident occurred:_____

Name of the driver of the ***other*** vehicle: _____

Auto Insurance company name : _____ Policy # _____

Claim adjustor name: _____ Claim # _____

Phone # _____

Name of the driver of the car ***you were*** in: _____

Auto Insurance company name: _____ Policy # _____

Is there ***Med Pay*** on this policy? _____ Amount $ _____

Claim adjustor name: _____ Claim # _____

Phone # _____

Were the police notified: ☐ Yes ☐ No ⟹ If so please provide us with a copy of the report.

Signature: _____ Date: _____

Patient Health Questionnaire

Patient Name_____ **Date**_____

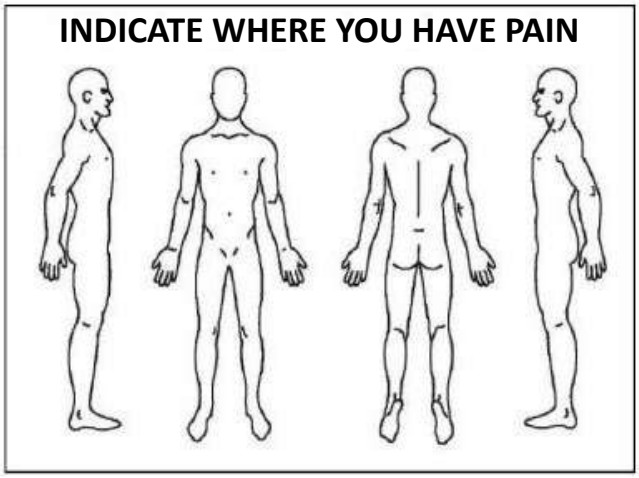
1. What are your current symptoms (List the worst one first):

_____

_____

_____

_____



2. How long have you had your main symptom?

This episode: _____

First episode EVER: _____

3. How often are your symptoms present?
□ Occasional (0-25%) □ Frequent (50-75%)
□ Intermittent (25-50%) □ Constant (75-100%)

4. What do you feel caused your symptoms?
□ Car Accident □ Fall □ Sports Injury □ Lifting
□ Work □ Posture □ Other_____

5 What have you tried for your current complaint?

□ Nothing	□ Advil / Tylenol / Aleve (CIRCLE)	□ Chiropractic Care	□ Yoga
□ Prescription Pain Meds	□ Injections	□ Acupuncture	□ CBD
□ Muscle Relaxer	□ Massage Therapy	□ Physical Therapy	□ New Mattress / Pillow (CIRCLE)
□ Ice / Heat (CIRCLE)	□ Foam roller	□ Stretching	□ _____

6. Who else have you seen for your current symptoms?

□ No One	□ Medical Doctor / PCP	□ Neurologist	□ Acupuncturist
□ This Office	□ OBGYN / Midwife	□ Physical Therapist	□ OTHER _____
□ Other Chiropractor	□ Orthopedic Doctor	□ Massage Therapist	

7. What tests have you had for your symptoms?
□ None □ MRI date: _____
□ X-rays date :_____ □ CT Scan date: _____

8. What activities make your symptoms better?
□ Ice □ Rest □ Sitting □ Medication
□ Heat □ Activity □ Standing □ _____

9. What activities make your symptoms worse?
□ Ice □ Rest □ Sitting □ Medication
□ Heat □ Activity □ Standing □ _____

10. What describes the nature of your symptoms?
□ Dull □ Aching □ Numb □ Burning □ Tight / Stiff
□ Sharp with movement □ Shooting □ Tingling □ Sore

11. Do your symptoms radiate (travel)? □ Yes □ No If yes, to what part of your body? _____

12. What is the severity of your symptoms (CIRCLE the range)? **0 1 2 3 4 5 6 7 8 9 10**

13.What activities are affected by your symptoms?

□ Work/School (CIRCLE)	□ Exercise	□ Driving/Riding in Car (CIRCLE)	□ House Work	□ Mood
□ Getting dressed	□ Running	□ Caring for Children	□ Yard Work	□ Focus
□ Sleeping	□ Walking	□ Going up / down stairs	□ Bathing	□ _____

14. Have your symptoms been getting... □ Better □ Worse □ Staying the same

Please check any condition below that you had in the past or have currently...

16. PAST	17. PRESENT		16. PAST	17. PRESENT		16. PAST	17. PRESENT	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Low Blood Pressure	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	High Cholesterol	□	□	Excessive Urination
□	□	Mid Back Pain	□	□	Heart Attack	□	□	Hypo-Thyroid
□	□	Low Back Pain	□	□	Chest Pains	□	□	Hyper-Thyroid
□	□	Scoliosis	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Shoulder Pain	□	□	Angina	□	□	Drug/Opioid Dependence
□	□	Elbow Pain	□	□	Kidney Stones	□	□	Alcohol Dependence
□	□	Wrist Pain	□	□	Kidney Disorder	□	□	Food Allergies
□	□	Hand Pain	□	□	Bladder Infection	□	□	Depression
□	□	Carpal Tunnel	□	□	Painful Urination	□	□	Anxiety
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Frequent Illness
□	□	Knee Pain	□	□	Prostate Problems	□	□	Epilepsy
□	□	Ankle Pain	□	□	Reflux/Heartburn	□	□	Dermatitis
□	□	Foot Pain	□	□	Abnormal Weight Gain	□	□	Eczema
□	□	Sciatica	□	□	Abnormal Weight Loss	□	□	Poison Ivy/Oak
□	□	Jaw Pain/TMJ	□	□	Loss of Appetite	□	□	HIV/AIDS
□	□	Osteopenia	□	□	Constipation			
□	□	Osteoporosis	□	□	Abdominal Pain			
□	□	Joint Swelling/Stiffness	□	□	Ulcer	***Females Only***		
□	□	Arthritis	□	□	Hepatitis			
□	□	Rheumatoid Arthritis	□	□	Liver Disorder	□	□	Hot Flashes
□	□	Lyme Disease	□	□	Gall Bladder Disorder	□	□	Hormone Replacement
□	□	General Fatigue	□	□	Cancer	□	□	Birth Control Pills
□	□	Ringing in Ears	□	□	Tumor	□	□	Painful Periods/Cramps
□	□	Visual Disturbances	□	□	Asthma			
□	□	Dizziness	□	□	Chronic Sinusitis	YES	NO	Are You Pregnant?
□	□	Nausea	□	□	Seasonal Allergies			

18. Primary Care Physician_____ **18b. Date of Last Medical Physical**_____

19. Indicate if an immediate family member has had any of the following:

□ Rheumatoid Arthritis □ Heart Problems □ Diabetes □ Cancer □ Lupus □ Other: _____

20. List all prescription and over-the-counter medications, nutritional/herbal supplements, essential oils, or CBD you are taking:

_____

21. List all the surgical procedures you have had AND times you have been hospitalized (INLCUDING GIVING BIRTH):

_____

_____

22. ANY & ALL LIFETIME TRAUMA HISTORY, EVEN IF YOU DID NOT HAVE SYMPTOMS OR TREATMENT:

Auto Accidents:_____

Falls: _____

Sports Injuries:_____

Concussions:_____

Other Physical Traumas: _____

23. Age of Mattress:_____ years Sleep Position: □ back □ side □ stomach # of pillows under your head?_____

PATIENT SIGNATURE:_____ **Date:**_____