PERSONAL INFORMATION

Patient Name _____ Date _____

Phone # _____ Cell # _____Work # _____ E-mail _____

Address _____ City _____ State _____ Zip _____

DOB _____/_____/_____ Age _____ Sex: ☐M ☐F Height: _____ Weight: _____

Employer: _____ Type of Work: _____

SS # _____ Referred to This Office By: _____

Ins. Co. _____ Policy # _____ Case # _____

AUTO ACCIDENT INFORMATION

Date and time of accident: _____ ☐a.m. ☐p.m.

Were you the: ☐Driver ☐Front Passenger ☐Rear passenger

Make and model of the vehicle you were occupying? _____

If a traffic violation was issued, to who was it issued? _____

Number of people in accident vehicle? _____

Did the police come to the accident site? ☐Yes ☐No

Was a police report filed? ☐Yes ☐No

Were there any witnesses? ☐Yes ☐No

Were you wearing a seat belt? ☐Yes ☐No

Was this vehicle equipped with airbags? ☐Yes ☐No

If yes, did it/ they inflate? ☐Yes ☐No

In relation to the base of your skull, where was the headrest? ☐Above ☐Below ☐At base of skull

What did your vehicle impact? ☐Another vehicle ☐Other

If other, explain: _____

Did any part of your body strike anything in the vehicle? ☐Yes ☐No

If yes, please describe: _____

Name of the location/ street on which you were traveling? _____

In which direction were you headed? ☐N ☐S ☐E ☐W

What was the approx. speed of your vehicle? _____

Did the impact to your vehicle come from the: ☐Front ☐Rear ☐Right Side ☐Left Side ☐Other

During impact, were you facing: ☐Right ☐Left ☐Forward

Were you ☐aware or ☐surprised by the impact?

If accident vehicle made impact with another vehicle…

Direction other vehicle was headed? ☐N ☐S ☐E ☐W

Approximate Speed of the other vehicle? _____

In your words, please describe the accident:

_____

_____

_____

AFTER INJURY

Did accident render you unconscious? ☐ Yes ☐ No

If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

Have you gone to a hospital or seen any other Doctor? ☐ Yes ☐ No

When did you go? ☐ Just after accident ☐ The next day ☐ 2 days plus

How did you get there? ☐ Ambulance ☐ Private transportation

Name of hospital and/ or attending doctor: _____

Was he/she a: ☐ D.C. ☐ M.D. ☐ D.O. ☐ D.D.S.

Describe any treatment you received: _____

Were X-Rays taken? ☐ Yes ☐ No

Was medication prescribed? ☐ Yes ☐ No

Have you been able to work since this injury? ☐ Yes ☐ No

Are your work activities restricted as a result of this injury? ☐ Yes ☐ No

Indicate the symptoms that are a result of this accident:

☐ Dizziness	☐ Memory loss	☐ Headache(s)	☐ Blurred vision
☐ Buzzing in ear	☐ Ears ringing	☐ Difficulty Sleeping	☐ Irritability
☐ Fatigue	☐ Tension	☐ Neck pain	☐ Neck stiff
☐ Jaw problems	☐ Arms/ shoulder pain	☐ Numb hands/fingers	☐ Chest pain
☐ Stomach upset	☐ Shortness of breath	☐ Back pain	☐ Nausea
☐ Lower back pain	☐ Back stiffness	☐ Numb feet/ toes	☐ Leg Pain

Other _____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that The Chiropractic Experience will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and adjustment plan, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor of Chiropractic to adjust my vertebral subluxations as he deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnoses.

Patient Signature X _____ Date _____

Guardian or Spouse Authorizing Care _____ 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 understand both the objective and the method that will be used 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 subluxation. 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 and infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae 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 examination, we encounter non-chiropractic or unusual 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 questioning 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)