

Freedom Family Chiropractic

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1. Dear Patient: This information is considered confidential. Your answers will help us determine if chiropractic care can help your condition. We will not accept your case if we do not believe your condition will respond satisfactorily to care. In order for us to understand your condition properly, please be as accurate as possible while completing this form. Thank you. Please answer all questions completely.

First Name

-

Last Name

-

Please explain in detail how your accident happened:

-

What was the date of the accident?

-

What was the approximate time of the accident?

-

Did you feel pain immediately after the accident?

☐ Yes ☐ No

If yes, where was the pain?

-

Where were you taken after the accident?

-

Were you hospitalized?

☐ Yes ☐ No

If yes, admitted?

☐ Yes ☐ No

How long?

-

Name of Hospital:

-

Name of Doctor(s):

-

What treatment was given?

-

Was any other doctor consulted after your accident?

☐ Yes ☐ No

If so, what was the doctor's name?

-

What was the diagnosis?

-

What treatment was given?

-

How often did you see the doctor?

-

How long did you see the doctor?

-

Have you ever had any complaints in the involved area before?

☐ Yes ☐ No

If so, what were the complaints?

-

Before the injury were you capable of working on an equal basis with others your age?

☐ Yes ☐ No

Are your work activities restricted as a result of this accident?

☐ Yes ☐ No

Since this injury are your symptoms ...

☐ Improving
☐ Getting worse
☐ Same

Name of driver of vehicle in which you were injured (if applicable):

-

Insurance Company

-

Name of your insurance adjustor

-

Have you retained an attorney?

☐ Yes ☐ No

If so, his/her name and address

-

You were heading North/ East/ South/ West on (street or highway)

-

Other vehicle was heading North/ East/ South/ West on (street or highway)

-

Were police notified?

☐ Yes ☐ No

Were you knocked unconscious

☐ Yes ☐ No

If yes, for how long?

-

You were struck from Behind/ Front/ Left Side/ Right Side

-

You were Driver/ Passenger/ Front seat/ Back Seat/ Using seat belts

-

2. Check symptoms you have noticed since the accident:

- | | | |
|---|---|---|
| ☐ Headache | ☐ Light Bothers Eyes | ☐ Head Seems Too Heavy |
| ☐ Pins and Needles in Arms | ☐ Sleeping Problems | ☐ Pins and Needles in Legs |
| ☐ Numbness in Fingers | ☐ Numbness in Toes | ☐ Shortness of Breath |
| ☐ Neck Pain | ☐ Loss of Balance | ☐ Cold Sweats |
| ☐ Dizziness | ☐ Buzzing in Ears | ☐ Memory Loss |
| ☐ Ears Ring | ☐ Back Pain | ☐ Constipation |
| ☐ Loss of Smell | ☐ Loss of Taste | ☐ Stomach Upset |
| ☐ Neck Stiff | ☐ Nervousness | ☐ Depression |
| ☐ Diarrhea | ☐ Feet Cold | ☐ Hands Cold |
| ☐ Face Flushed | ☐ Tension | ☐ Fever |
| ☐ Chest Pain | ☐ Fatigue | ☐ Fainting |
| ☐ Irritability | | |

I certify that the information contained in my accident history is correct to the best of my knowledge. I will not hold my doctor or any staff member of Freedom Family Chiropractic responsible for any errors or omissions that I may have made in the completion of this form.

Signature

Date Signed

-

Printed Name

Email

-

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