



N2120 County Road S Antigo, WI 54409

PATIENT AUTOMOBILE ACCIDENT HISTORY

TODAY'S DATE: _____

PERSONAL INFORMATION

NAME:		HOME PHONE:
STREET ADDRESS:		WORK PHONE:
CITY/STATE/ZIP:		CELL PHONE:
DATE OF BIRTH:		EMAIL:
SOCIAL SECURITY #:		
DRIVER'S LICENSE#:		
SPOUSE'S NAME:		SPOUSE'S EMPLOYER:
EMERGENCY CONTACT:		EMERGENCY CONTACT'S PHONE:
<input type="checkbox"/> Yes <input type="checkbox"/> No DO YOU COMMUTE TO WORK? IF SO, HOW FAR?		
OCCUPATION:		EMPLOYER:
<input type="checkbox"/> Yes <input type="checkbox"/> No HAVE YOU MISSED TIME FROM WORK? IF NO, WHO TOLD YOU TO RETURN TO WORK?		
IF YES, WERE YOU OFF WORK FULL-TIME?		<input type="checkbox"/> Yes <input type="checkbox"/> No DATES:
WERE YOU OFF WORK PART-TIME?		<input type="checkbox"/> Yes <input type="checkbox"/> No DATES:
COMPLETELY OFF WORK?		<input type="checkbox"/> Yes <input type="checkbox"/> No DATES:
WHAT TYPE OF PHYSICAL ACTIVITY IS REQUIRED OF YOU AT WORK?		
IS THERE ALTERNATIVE WORK AVAILABLE FOR YOU? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Yes <input type="checkbox"/> No ARE YOU A SMOKER? IF SO, HOW MUCH?		
<input type="checkbox"/> Yes <input type="checkbox"/> No DO YOU CONSUME CAFFEINE? IF SO, HOW MUCH?		
<input type="checkbox"/> Yes <input type="checkbox"/> No ARE YOU A FEMALE? IF SO, ARE YOU PREGNANT? <input type="checkbox"/> Yes <input type="checkbox"/> No		

AUTO INFORMATION

YOUR CAR INSURANCE COMPANY:	
AGENT'S NAME:	AGENT'S PHONE #:

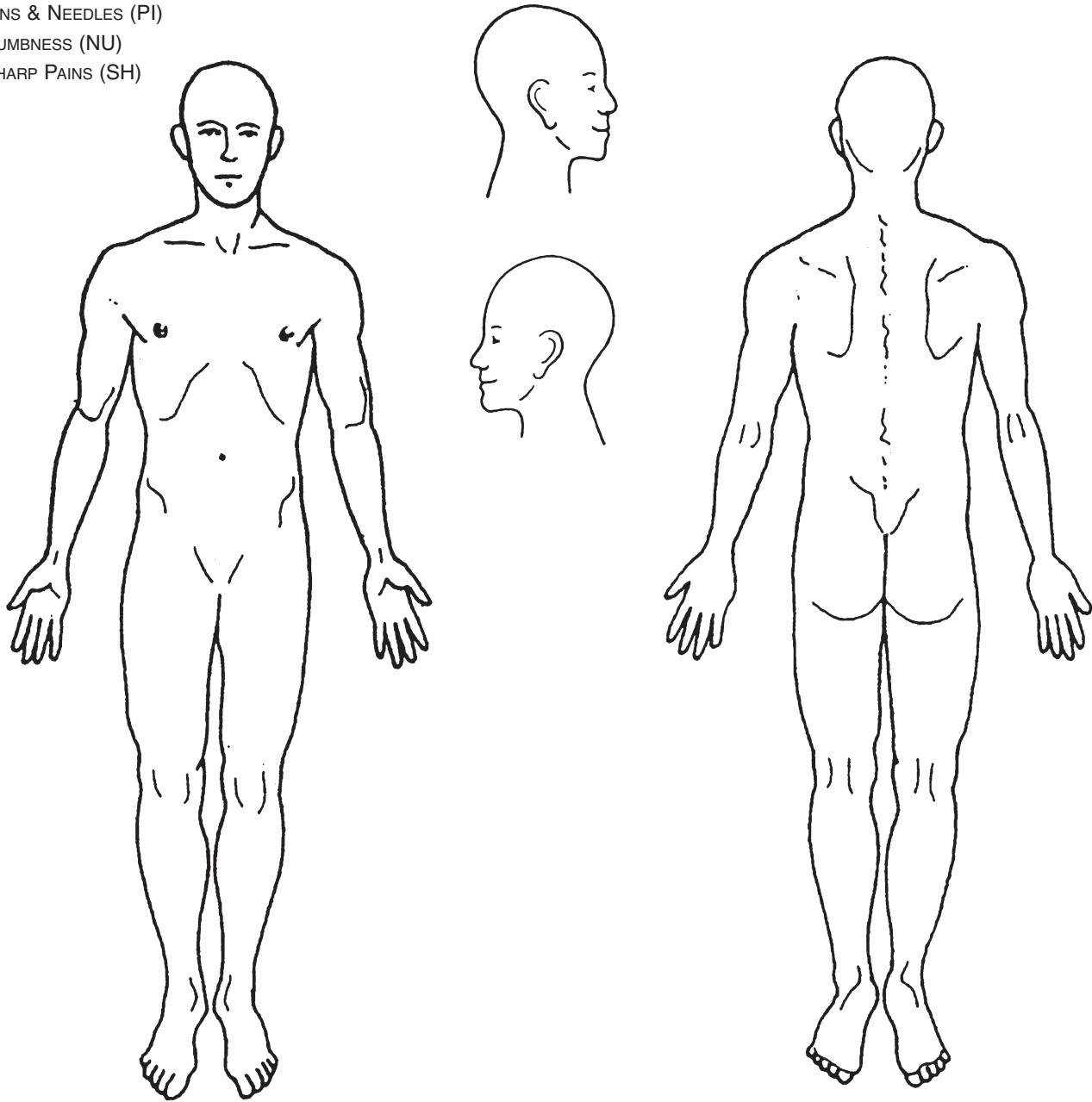
PAST MEDICAL HISTORY

<input type="checkbox"/> Yes <input type="checkbox"/> No DO YOU SUFFER FROM ANY CONDITION OTHER THAN THAT FOR WHICH YOU ARE NOW CONSULTING US? IF YES, WHAT?	
<input type="checkbox"/> Yes <input type="checkbox"/> No HAVE YOU EVER SEEN A CHIROPRACTOR BEFORE?	
DATE:	DOCTOR: CONDITION:
<input type="checkbox"/> Yes <input type="checkbox"/> No ARE YOU ALLERGIC TO ANYTHING? IF SO, WHAT?	
<input type="checkbox"/> Yes <input type="checkbox"/> No DO YOU TAKE PRESCRIPTION DRUGS, OVER-THE-COUNTER DRUGS, VITAMINS OR SUPPLEMENTS? IF YES, PLEASE LIST DRUG, REASON, FREQUENCY AND DOSAGE.	
<input type="checkbox"/> Yes <input type="checkbox"/> No HAVE YOU EVER HAD MAJOR ILLNESSES, INJURIES, FALLS, HOSPITALIZATIONS, AUTO ACCIDENTS OR SURGERIES? IF YES, PLEASE LIST DATES AND CONDITIONS.	

CHIEF COMPLAINT

BE SURE TO FILL OUT THIS SECTION AS ACCURATELY AS POSSIBLE. MARK THE AREA WITH THE DESCRIBED SENSATION. USE THE APPROPRIATE SYMBOLS.
 IF THERE IS MORE THAN ONE AREA OF DISCOMFORT, PLEASE RATE THE PAIN ON A SCALE OF 0 TO 100 NEXT TO EACH AREA, WITH 0 BEING NO PAIN AND 100 BEING INTOLERABLE PAIN.

- XXX BURNING (BU)
- (((ACHING PAIN (AC)
- 000 PINS & NEEDLES (PI)
- - - NUMBNESS (NU)
- ::: SHARP PAINS (SH)



WHAT MAKES THE CONDITION BETTER?

HEAD NECK _____
 MID BACK _____
 LOW BACK _____
 SHOULDER, ARM, HAND _____
 HIP, LEG, FOOT _____
 OTHER _____

WHAT MAKES THE CONDITION WORSE?

HEAD NECK _____
 MID BACK _____
 LOW BACK _____
 SHOULDER, ARM, HAND _____
 HIP, LEG, FOOT _____
 OTHER _____

ACCIDENT INFORMATION

DATE OF ACCIDENT:	TIME OF ACCIDENT: <input type="checkbox"/> AM <input type="checkbox"/> PM
DRIVER OF VEHICLE:	WHERE WERE YOU SEATED:
VEHICLE'S OWNER:	YEAR/MODEL OF VEHICLE YOU WERE IN:
APPROXIMATE DAMAGE OF THE VEHICLE YOU WERE IN:	WHERE DID THE ACCIDENT OCCUR:
YOUR VEHICLE: <input type="checkbox"/> HIT ANOTHER VEHICLE <input type="checkbox"/> WAS HIT IN THE: <input type="checkbox"/> RIGHT SIDE <input type="checkbox"/> LEFT SIDE <input type="checkbox"/> REAR <input type="checkbox"/> FRONT	
TYPE OF ACCIDENT: <input type="checkbox"/> HEAD-ON COLLISION <input type="checkbox"/> BROAD-SIDE COLLISION <input type="checkbox"/> REAR-END COLLISION <input type="checkbox"/> FRONT-IMPACT (REAR-ENDED VEHICLE IN FRONT) <input type="checkbox"/> SINGLE VEHICLE COLLISION <input type="checkbox"/> OTHER	
WERE THE INTERNAL PARTS OF THE VEHICLE BROKEN? <input type="checkbox"/> YES <input type="checkbox"/> NO IF SO, WHICH ONES?	
WHAT WERE THE ROAD CONDITIONS AT THE TIME: <input type="checkbox"/> ICY <input type="checkbox"/> RAINY <input type="checkbox"/> WET <input type="checkbox"/> CLEAR <input type="checkbox"/> DARK	
WHAT WAS THE VISIBILITY AT THE TIME: <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> GOOD	
NUMBER OF VEHICLES INVOLVED: 1 2 3 4 5 +	YEAR/MODEL OF OTHER VEHICLE(S):

IMPACT/SEATBELT/HEADREST/SPEED/HEAD/BODY POSITION

DESCRIBE IN YOUR OWN WORDS WHAT HAPPENED TO YOU UPON IMPACT:

YES NO DID YOU SEE THE ACCIDENT COMING?

YES NO DID YOU BRACE FOR IMPACT?

YES NO DID YOU HAVE YOUR HANDS ON THE STEERING WHEEL AT IMPACT?

YES NO WERE YOU WEARING GLASSES, A HAT OR DENTURES? WHERE WERE THEY AFTER THE IMPACT?

YES NO WERE SEATBELTS WORN? YES NO WERE SHOULDER HARNESSES WORN?

YES NO DOES YOUR VEHICLE HAVE AIRBAGS? YES NO DID THEY RELEASE?

YES NO DOES YOUR VEHICLE HAVE HEADRESTS? IF SO, WHAT WAS ITS POSITION COMPARED TO YOUR HEAD AFTER THE ACCIDENT?

YES NO WAS YOUR VEHICLE BRAKING?

YES NO WAS YOUR VEHICLE MOVING AT THE TIME OF THE ACCIDENT? SLOWING DOWN SPEEDING UP CONSTANT SPEED

WHAT WAS THE SPEED LIMIT ON THE ROAD YOU WERE TRAVELING?

HOW MANY PEOPLE WERE IN YOUR VEHICLE?

HEAD/BODY POSITION AT THE TIME OF IMPACT:

HEAD: STRAIGHT TURNED RIGHT TURNED LEFT

BODY: STRAIGHT TURNED RIGHT TURNED LEFT

YES NO DID YOUR HEAD/BODY HIT ANY PARTS OF THE INTERIOR OF THE VEHICLE? IF YES, WHICH PARTS?

ABILITY TO MOVE BODY

YES NO COULD YOU MOVE ALL PARTS OF YOUR BODY? IF NO, WHAT PARTS AND WHY NOT?

YES NO WERE YOU ABLE TO GET OUT OF THE VEHICLE UNAIDED? IF NO, WHY NOT?

AS A RESULT OF THE ACCIDENT WERE YOU: RENDERED UNCONSCIOUS DAZED, SITUATION VAGUE SHAKEN UP BUT COULD FUNCTION

WHERE WERE YOU IN THE VEHICLE PRIOR TO THE ACCIDENT?

WHERE WERE YOU IN THE VEHICLE AFTER THE ACCIDENT?

INDICATE YOUR ABILITY TO PERFORM THE FOLLOWING ACTIVITIES. PLEASE USE THESE CODES:

U – UNABLE L – LIMITED P – PAINFUL D – DIFFICULT N – NORMAL H – HAVEN'T TRIED

LYING ON BACK	GRIPPING	PUSHING	TURNING OVER IN BED
LYING ON SIDE	CLIMBING	KNEELING	STANDING 1 HR+
BENDING FORWARD	PULLING	STOOPING	WALKING SHORT DISTANCES
GETTING IN/OUT CAR	DRESSING SELF	SITTING AT TABLE	COUGH/SNEEZE
SLEEPING	SEXUAL ACTIVITY	REACHING	LYING FLAT ON STOMACH
BALANCING	OTHER ACTIVITIES:		

FIRST DOCTOR/HOSPITAL/CLINIC

YES NO DID YOU SEEK MEDICAL HELP IMMEDIATELY AFTER THE ACCIDENT? IF YES, HOW DID YOU GET THERE?

SOMEONE DROVE YOU YOU DROVE POLICE AMBULANCE

WHERE DID YOU GO?

YES NO WERE YOU EXAMINED?

YES NO WERE X-RAYS TAKEN?

YES NO WERE YOU GIVEN TREATMENT? IF SO, WHAT TYPE?

DID YOU RECEIVE ANY BENEFIT FROM THIS TREATMENT?

DATE OF YOUR LAST TREATMENT?

YES NO DID THE DOCTOR REFER YOU TO ANOTHER HEALTH PROFESSIONAL? IF SO, TO WHO AND FOR WHAT?

YES NO DID YOU FOLLOW THE DOCTOR'S RECOMMENDATIONS? IF NO, WHY NOT?

SECOND DOCTOR/CLINIC

DOCTOR/CLINIC:

DATE OF FIRST VISIT:

YES NO WERE YOU EXAMINED?

YES NO WERE X-RAYS TAKEN?

YES NO WERE YOU GIVEN TREATMENT? IF YES, WHAT TYPE?

WHAT BENEFITS DID YOU RECEIVE FROM THIS TREATMENT?

DATE OF LAST TREATMENT?

SYMPTOMS FROM ACCIDENT

Yes No DID YOU RECEIVE ANY BRUISES FROM THE SEATBELTS? IF SO, WHERE?

Yes No DID YOU RECEIVE ANY OTHER BLEEDING CUTS OR BRUISES? IF CUT, WHERE?
IF BRUISES, WHERE?

PLEASE DESCRIBE HOW YOU FELT. PLEASE BE SPECIFIC.

IMMEDIATELY AFTER THE ACCIDENT:

LATER THAT DATE:

THE NEXT DAY(S):

CHECK SYMPTOMS THAT HAVE BECOME APPARENT SINCE THE ACCIDENT/INJURY:

NERVOUSNESS	LOSS OF BALANCE	SLEEPING TROUBLE	HEADACHE
NECK PAIN/STIFFNESS	LOSS OF SMELL	TOE NUMBNESS	FAINING
MID BACK PAIN	LOSS OF TASTE	FINGER NUMBNESS	ANXIETY
LOW BACK PAIN	LOSS OF MEMORY	COLD HANDS	SEIZURES
EYE SENSITIVITY	PINS/NEEDLES ARMS	COLD FEET	VISUAL CHANGES
PAIN BEHIND EYES	PINS/NEEDLES LEGS	CHEST PAIN	FORGETFULNESS
DIZZINESS	SHORT OF BREATH	CONSTIPATION	BLURRED VISION
COLD SWEATS	HEAD BEING HEAVY	DIARRHEA	DOUBLE VISION
FACE FLUSHED	IRRITABILITY	FATIGUE	CONFUSED
RINGING IN EARS	DEPRESSION	TENSION	DISORIENTED

Yes No DOES THE PAIN INTERFERE WITH YOUR SLEEP? IF SO, HOW MANY TIMES PER NIGHT?

Yes No DOES HEAT AFFECT THE PAIN? IF SO, HOW?

Yes No DOES COLD AFFECT THE PAIN? IF SO, HOW?

Yes No DO YOU WEAR A HEEL LIFT? IF SO, WHICH SIDE?

Yes No DID YOU HAVE ANY PHYSICAL COMPLICATIONS JUST BEFORE THE ACCIDENT? IF YES, PLEASE DESCRIBE IN DETAIL:

Yes No PRIOR TO THIS ACCIDENT, HAVE YOU EVER HAD SIMILAR SYMPTOMS? IF YES, PLEASE EXPLAIN.

Yes No HAVE YOU BEEN IN ACCIDENTS PRIOR TO THIS ONE? IF YES, WHEN? WHERE?

HOW WERE YOU TREATED?

RESULTS OF TREATMENT.

Yes No DO YOU HAVE ANY CONGENITAL (BIRTH) FACTORS WHICH RELATE TO THIS PROBLEM? IF YES, PLEASE DESCRIBE:

HAVE YOU HAD ANY PROBLEMS WITH THE FOLLOWING AREAS? MARK Y IF YES – MARK N IF NO

EYES	URINARY	INTERNAL ORGANS	EARS, NOSE, MOUTH
MUSCLES	BLOOD	HEART	NERVES
ALLERGIES	LUNGS/BREATHING	SKIN	OTHER
INTESTINES	PSYCHOLOGICAL		

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT ALL OF THE ABOVE STATEMENTS ARE TRUE. I HEREBY AUTHORIZE THE DOCTOR TO EXAMINE AND TREAT MY CONDITION AS HE/SHE DEEMS APPROPRIATE THROUGH THE USE OF CHIROPRACTIC HEALTH CARE, AND I GIVE AUTHORITY FOR THESE PROCEDURES TO BE PERFORMED. I ALSO GIVE PERMISSION FOR MY CASE TO BE USED FOR RESEARCH PURPOSES IF IT IS SO APPROVED.

PATIENT SIGNATURE: _____ DATE: _____

GUARDIAN/LEGAL REPRESENTATIVE SIGNATURE: _____ DATE: _____

D.C./C.A. SIGNATURE: _____ DATE: _____

INFORMED CONSENT

CHIROPRACTIC, AS WELL AS OTHER TYPES OF HEALTH CARE, IS ASSOCIATED WITH POTENTIAL RISKS IN THE DELIVERY OF TREATMENT. THEREFOR IT IS NECESSARY TO INFORM THE PATIENT OF SUCH RISKS PRIOR TO INITIATING CARE. WHILE CHIROPRACTIC TREATMENT IS REMARKABLY SAFE, YOU NEED TO BE INFORMED ABOUT THE POTENTIAL RISKS RELATED TO YOUR CARE TO ALLOW YOU TO BE FULL INFORMED IN CONSENTING TO TREATMENT.

CHIROPRACTIC OFFICES USE TRAINED STAFF PERSONNEL TO ASSIST WITH PORTIONS OF YOUR CONSULTATION, EXAMINATION, X-RAYS, PHYSICAL THERAPY APPLICATIONS, EXERCISE INSTRUCTION, ETC. OCCASIONALLY, WHEN YOUR CHIROPRACTOR IS UNAVAILABLE, ANOTHER QUALIFIED DOCTOR OF CHIROPRACTIC MAY TREAT YOU.

SPECIFIC RISK POSSIBILITIES ASSOCIATED WITH CHIROPRACTIC CARE:

STROKE- STROKE IS THE MOST SERIOUS COMPLICATION OF CHIROPRACTIC TREATMENT. IT IS, ON RARE OCCASIONS, DUE TO INJURY OF THE VERTEBRAL ARTERY CAUSED BY A CERVICAL SPINE ADJUSTMENT OR MANIPULATION, AND WHEN OCCURS, MAY CAUSE TEMPORARY OR PERMANENT BRAIN DYSFUNCTION. ON EXTREMELY RARE OCCASIONS DEATH OCCURS. BECAUSE THE VERTEBRAL ARTERIES, WHICH SUPPLY THE BRAIN WITH BLOOD, ARE LOCATED WITHING THE BONES OF THE CERVICAL SPINE, CERVICAL TREATMENT POSES A SMALL RISK. THE CHANCES OF THIS OCCURRING ARE ESTIMATED AT 1 PER 400,000 TREATMENTS TO 1 TO 5.85 MILLION TREATMENTS. (CMAJ 2001 OCT. 2; 165 (7):905-6). THE ANNUAL INCIDENCE OF A SPONTANEOUS STROKE IS ESTIMATED AT 1 TO 1.5 PER 100,000 (NEJM, 1994; 330:339-397). THE RESULTS OF A RETROSPECTIVE STUDY CONDUCTED BY HALDEMAN S, ET. AL, SUGGESTED THAT STROKE SHOULD BE CONSIDERED A RANDOM AND UNPREDICTABLE COMPLICATION OF ANY NECK MOVEMENT INCLUDING CERVICAL MANIPULATION (J NEUROL 2002 Aug; 249(8): 1098-104).

SORENESS- CHIROPRACTIC ADJUSTMENTS AND PHYSICAL THERAPY PROCEDURES ARE SOMETIMES ACCOMPANIED BY POST TREATMENT SORENESS. THIS IS A NORMAL AND ACCEPTABLE ACCOMPANYING RESPONSE TO CHIROPRACTIC CARE. WHILE IS IS NOT GENERAL DANGEROUS, PLEASE ADVISE YOUR DOCTOR OF CHIROPRACTIC IF YOU EXPERIENCE SORENESS OR DISCOMFORT.

SOFT TISSUE INJURY- OCCASIONALLY CHIROPRACTIC TREATMENT MAY AGGRAVATE A DISC INJURY, OR CAUSE OTHER MINOR JOINT, LIGAMENT, TENDON, OR OTHER SOFT TISSUE INJURY.

RIB INJURY- MANUAL ADJUSTMENTS TO THE THORACIC SPINE, IN RARE CASES, MAY CAUSE RIB INJURY OR FRACTURE. PRECAUTIONS SUCH AS PRE-ADJUSTMENT X-RAYS ARE TAKEN FOR CASES CONSIDERED AT RISK. TREATMENT IS PERFORMED CAREFULLY TO MINIMIZE SUCH RISK.

PHYSICAL THERAPY BURNS- HEAT GENERATED BY PHYSICAL THERAPY MODALITIES MAY CAUSE MINOR BURNS TO THE SKIN. THESE ARE RARE, BUT SHOULD BE REPORTED TO YOUR DOCTOR OF CHIROPRACTIC OR STAFF IF THEY OCCUR.

OTHER PROBLEMS- THERE ARE OCCASIONALLY OTHER TYPES OF SIDE EFFECTS ASSOCIATED WITH CHIROPRACTIC CARE. WHILE THESE ARE RARE, THEY SHOULD BE REPORTED TO YOUR DOCTOR OF CHIROPRACTIC PROMPTLY.

CHIROPRACTIC IS A SYSTEM OF HEALTH CARE DELIVERY AND THEREFORE, AS WITH ANY HEALTH CARE DELIVERY SYSTEM, WE CANNOT PROMISE A CURE FOR ANY SYMPTOM, CONDITION, OR DISEASE AS A RESULT OF TREATMENT IN THIS OFFICE. AN ATTEMPT TO PROVIDE THE VERY BEST CARE IS YOUR GOAL AND IF THE RESULTS ARE NOT ACCEPTABLE, WE WILL REFER YOU TO ANOTHER PROVIDER WHO WE FEEL WILL ASSIST YOUR SITUATION.

IF YOU HAVE ANY QUESTIONS CONCERNING THE ABOVE, PLEASE ASK YOUR DOCTOR OF CHIROPRACTIC. WHEN YOU HAVE FULL UNDERSTANDING AND CONSENT TO HAVE CARE PROVIDED, PLEASE PRINT YOUR NAME AND SIGN AND DATE BELOW.

HAVING CAREFULLY READ THE ABOVE, I HEREBY GIVE MY INFORMED CONSENT TO HAVE CHIROPRACTIC TREATMENT ADMINISTERED.

PATIENT'S NAME PRINTED

TODAY'S DATE

PATIENT'S SIGNATURE

PARENT OF GUARDIAN SIGNATURE FOR MINOR
