ACCIDENT/INJURY QUESTIONNAIRE

Name: (Last, First MI)______________________________________ **Today's Date:** ___________

AUTOMOBILE ACCIDENT – ADDITIONAL INFORMATION

- **Was anyone else in the vehicle with you?** ☐ **No** ☐ **Yes -** *(Number of people)* _______
- **You were?** ☐ **Front seat –** *Driver / Passenger* ☐ **Rear Seat**– Behind Driver / Middle / Behind Passenger / 2nd Row / 3rd Row
- **Name of Driver**, *if not self*: ____________________ **Name of Driver of other vehicle:** _________________________________
- **Did airbags deploy?** ☐ **No** ☐ **Yes** **Did Police arrive?** ☐ **No** ☐ **Yes** **Using Seatbelt?** ☐ **No** ☐ **Yes**
- **Did you strike the windshield or object in car?** ☐ **No** ☐ **Yes** **-** *(Describe)* ____
- **Were you knocked unconscious?** ☐ **No** ☐ **Yes** *(How long?)* _________
- **Where was your vehicle impacted?** Front / Rear / Passenger Side / Driver's Side / Other: ___________________________
- **Where was the other vehicle impacted?** Front / Rear / Passenger Side / Driver's Side / Other: ___________________________
- **Your Auto Ins:** _________________ **Policy #:** _____________ **Claim #:** _____________________ **Phone #:**_____________
  - **Address:** ____ **City:** _____________________ **State:** _______ **Zip:** ___________
- **Other's Auto Ins:** _________________ **Policy #:** _______________ **Claim #:** _____________________ **Phone #:**___________
  - **Address:** ____ **City:** _____________________ **State:** _______ **Zip:** ___________

WORKER'S COMPENSATION INJURY – ADDITIONAL INFORMATION

Employer: __________________________________ **Occupation:** _________________ **Claim #:** ___________________________

Address: __________________________________ **City:** ________________________ **State:** ________ **Zip:** ________________

Contact Person: _____________________________ **Phone:** ______________________ **Email:** ____________________________

GENERAL ACCIDENT/INJURY INFORMATION – (*PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED*)

Date of Accident: ____/____/______ **Time**: ___:_____ AM / PM

Please describe the accident in as much detail as possible? ____

____

____

____

Before the accident/injury:

- **Have you ever had any complaints in the involved area before?** ☐ **No** ☐ **Yes**
  - *If yes* - **Were they present at the time of the accident/injury?** ☐ **No** ☐ **Yes**
    - *If yes* - **Summarize these complaints prior to the accident:** ____
- **Were you capable of performing all of your work activities without restriction?** ☐ **No** ☐ **Yes**

At the time of the accident/injury:

- **Did you feel pain immediately after the accident?** ☐ **No** ☐ **Yes** ☐ **Later that day** ☐ **Next day** ☐ **When?** ______________
- **Were you taken anywhere after the accident?** ☐ **No** ☐ **Yes** ☐ **Later that day** ☐ **Next day** ☐ **When?** ________________
  - *If yes,* **How?**___________________________ **Where?**_________________________
  - *If yes,* **Did you receive treatment?** ☐ **No** ☐ **Yes -** *(Describe)* ____

Since the accident/injury:

- **Are your symptoms:** ☐ **Improving?** ☐ **Getting Worse?** ☐ **The Same?**
- **Are your work activities restricted as a result of this accident/injury?** ☐ **No** ☐ **Yes -** *(How?)* ___________________________
- **Have you missed any work since this accident?** ☐ **No** ☐ **Yes -** *(Dates?)* ____
- **Have you retained an Attorney?** ☐ **No** ☐ **Yes - Name:**_______________________________ **Phone:** __________________
  - **Address:** ___________________________________ **City:** _____________________ **State:** _______ **Zip:** ____________

Patient No: ___________

© Pinnacle Management Group, Inc. 2013

CONFIDENTIAL PATIENT HEALTH HISTORY

Please PRINT clearly.

Today's Date: ________________________

PATIENT INFORMATION

Name: (Last, First, MI) ____ **Preferred Name**: ______________

Address: ________________________________ **City**: ______________________ **State**: _________ **Zip**: ___________

Home: ______________________ **Mobile**: ________________ **Mobile Carrier**: ______________ **Work**: ______________________

Email: ____ **Gender**: M / F **Marital Status**: Married / Single / Other

Best way to reach you: home / cell / work / email Date of Birth: _______________________ Age: ______________________

Preferred patient reminders: email / text Occupation: ________________________ Employer: ___________________

Who may we thank for referring you to our office? ____

CMS requires providers to report both race and ethnicity

Ethnicity: Not Hispanic or Latino / Hispanic or Latino / Other / Decline to Answer **Preferred Language**: __________________

Race: Asian / Black or African American / American Indian or Alaskan Native / White (Caucasian) / Native Hawaiian or Pacific Islander Other / Decline to Answer

Smoking Status: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: ______________________________________ **Name of Previous Chiropractor:** ______________________________

Home: _______________ **Mobile**: ___________________ **Date of Last Chiropractic Adjustment**: ________________________

Relationship: Child / Parent / Spouse / Other: ________ **Primary Care Physician**: ______________________________________

Doctor's Phone: ______________________________________

FINANCIAL INFORMATION -- ***Please allow our staff to photocopy your insurance card.***

Insurance Self Pay (Cash) Personal Injury/Auto Other (please explain) _________________________

PRIMARY INSURANCE

Name: ____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:
Insured's Name: ______________________ **Gender**: M / F

Address: ____

City: _________________ **State**: _________ **Zip**: ________

Phone: _______________ **Date of Birth**: ______________

SECONDARY INSURANCE

Name: ____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:
Insured's Name: ______________________ **Gender**: M / F

Address: ____

City: _________________ **State**: _________ **Zip**: ___________

Phone: _______________ **Date of Birth**: _________________

List all medications, Dosage and Frequency (i.e. 5 mg once a day, etc.) *Did you bring a list? Can we make a copy?*

____

____

____

CURRENT CONDITION INFORMATION *PLEASE ANSWER ALL QUESTIONS*

Describe **Major Complaint** for seeking care today: ____________________

Onset of Symptoms: _____________ Describe how it began:____________________

____

Severity of Complaint: None (0) Mild (1-2) Mild-Moderate (2-4) Moderate (4-6) Moderate-Severe (6-8) Severe (8-10)

Is the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Numb / Other: ____________________

How frequent is the complaint present? Constant Frequent Intermittent Occasional Infrequent

Does this complaint radiate/shoot to any areas of your body? No / Yes *(Describe)*____________________

Head - Base of Skull / Forehead / Sides-Temple R / L / Both Leg - Hip / Thigh-Knee / Foot-Toes R / L / Both

Arm - Across Shoulder / Elbow / Hand-Fingers R / L / Both *Other Area:*____________________

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: ____________________

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: ____________________

How does this condition affect your daily activities? *(Describe)* ____________________

Have you received any prior treatment for this condition?

DC / MD / PT / Massage / ER / Other: ____________________ Where? ____________________

Surgery? *(Describe)*____________________

Medications? OTC / Prescriptions *(Describe)*____________________

Diagnostic testing? X-rays / MRI / CT / Other:______________When and Where? ____________________

Describe any Secondary Complaints: ____________________

FAMILY HISTORY:

Heart Disease Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather

Stroke Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather

HEALTH HISTORY *(PLEASE USE REVERSE SIDE OF PAGE IF NEEDED)*

Cancer Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather

Type of Cancer: ____________________

Any other family history that might be relevant: ____________________

MEDICATION:

Allergies to Medications: *(List and reactions)* ____________________

____

____

Vitamins & Supplements: *(List all and frequency)* ____________________

____

____

PAST HEALTH HISTORY: *(List even if it was 20 years ago…)*

Surgeries – Date, Type and Reason:____________________

____

____

____

Major Injuries/Traumas: *(List even if it was 20 years ago or more…)*

____

____

____

Major Hospitalizations including year:

____

____

____

SOCIAL AND OCCUPATIONAL HISTORY:

Level of Education Completed:

High School / Some College / College Grad / Post Grad / Other

Lifestyle: *(Your Hobbies, Rec. Activities, Exercise, Diet, Health Goals)*

____

____

____

____

Habits:

Cigarettes – (#/day) ____________________

Alcohol – (amount/day)____________________

Coffee/Tea – (cups/day)____________________

Rec. Drugs: (list) ____________________

Are you <u>currently</u> experiencing any of these symptoms? *(Check all that apply)*

Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General: (constitutional)
- ❑ Recent Weight Change
- ❑ Fever
- ❑ Fatigue
- ❑ *None in this Category*

Musculoskeletal:
- ❑ Low Back Pain
- ❑ Mid Back Pain
- ❑ Neck Pain
- ❑ Arm Problems _______________
- ❑ Leg Problems _______________
- ❑ Painful Joints
- ❑ Stiff/Swollen Joints
- ❑ Sore/Weak Muscles or Joints
- ❑ Muscle Spasms/Cramps
- ❑ Broken Bones
- ❑ Other: ______________________
- ❑ *None in this Category*

Neurological:
- ❑ Numbness or Tingling Sensations
- ❑ Loss of Feeling
- ❑ Dizziness or Light Headed
- ❑ Frequent or Recurrent Headaches
- ❑ Convulsions or Seizures
- ❑ Tremors
- ❑ Stroke
- ❑ Have you ever had a head injury?
- ❑ Ever been in an auto accident?
- ❑ Other: ______________________
- ❑ *None in this Category*

Mind/Stress:
- ❑ Nervousness
- ❑ Depression
- ❑ Sleep Problems
- ❑ Memory Loss or Confusion
- ❑ Other: ______________________
- ❑ *None in this Category*

Genitourinary:
- ❑ Sexual Difficulty
- ❑ Kidney Stones
- ❑ Burning/Painful Urination
- ❑ Change in Force/Strain w/Urination
- ❑ Frequent Urination
- ❑ Blood in Urine
- ❑ Incontinence or Bed Wetting
- ❑ Other: ______________________
- ❑ *None in this Category*

Gastrointestinal:
- ❑ Loss of Appetite
- ❑ Blood in Stool
- ❑ Change in Bowel Movements
- ❑ Painful Bowel Movements
- ❑ Nausea or Vomiting
- ❑ Abdominal Pain
- ❑ Frequent Diarrhea
- ❑ Constipation
- ❑ Other: ______________________
- ❑ *None in this Category*

Cardiovascular & Heart:
- ❑ Chest Pains
- ❑ Rapid or Heartbeat Changes
- ❑ Blood Pressure Problems
- ❑ Swelling of Hands, Ankles, or Feet
- ❑ Heart Problems
- ❑ Other: ______________________
- ❑ *None in this Category*

Respiratory:
- ❑ Difficulty Breathing
- ❑ Persistent Cough
- ❑ Coughing Blood
- ❑ Asthma or Wheezing
- ❑ Lung Problems
- ❑ Other: ______________________
- ❑ *None in this Category*

Eyes and Vision:
- ❑ Wear contacts/glasses
- ❑ Blurred or Double Vision
- ❑ Glaucoma
- ❑ Eye Disease or Injury
- ❑ Other: ______________________
- ❑ *None in this Category*

Ears, Nose and Throat:
- ❑ Bleeding gums/Mouth sores
- ❑ Bad Breath or Bad Taste
- ❑ Dental Problems
- ❑ Swollen Throat or Voice Change
- ❑ Swollen Glands in Neck
- ❑ Ringing in the Ears
- ❑ Ear-Ache/Ringing/Drainage
- ❑ Sinus/Allergy Problems
- ❑ Nose Bleeds
- ❑ Hearing Loss
- ❑ Other: ______________________
- ❑ *None in this Category*

Endocrine, Hematologic, and Lymphatic:
- ❑ Thyroid problems
- ❑ Diabetes
- ❑ Excessive Thirst or Urination
- ❑ Cold Extremities
- ❑ Heat or cold Intolerance
- ❑ Change in hat or glove size
- ❑ Dry Skin
- ❑ Glandular or Hormone Problem
- ❑ Swollen Glands
- ❑ Anemia
- ❑ Easily Bruise or Bleed
- ❑ Phlebitis
- ❑ Transfusion
- ❑ Immune System Disorder
- ❑ Other: ______________________
- ❑ *None in this Category*

Skin and Breasts:
- ❑ Rash or Itching
- ❑ Change in Skin Color
- ❑ Change in Hair or Nails
- ❑ Non-healing Sores
- ❑ Change of Appearance of a Mole
- ❑ Breast Pain
- ❑ Breast Lump
- ❑ Breast Discharge
- ❑ Other: ______________________
- ❑ *None in this Category*

Women Only:

Are you pregnant?
- ❑ Yes-Due Date _______________
- ❑ No-Last Menstrual Period ______
- ❑ Infertility
- ❑ Painful or Irregular Periods
- ❑ Vaginal Discharge
- ❑ Other: ______________________
- ❑ *None in this Category*

Pregnancies with Outcome & Date

____

____

____

____

Is there anything else you would like the doctor to know? ____

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes. I choose to decline receipt of my clinical summary after every visit. (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient or Guardian Signature ____ Date________________

Treating Doctor Signature ____ Date________________