BACK TO CARE CHIROPRACTIC

Personal-Injury Case History

Information About you

Name_____ Phone_____ Email_____
Address_____City_____ State_____ Zip Code_____
Age_____ Date of Birth_____ Sex □M □F Social Security no._____
Employer's Name_____ Employer's Address_____
Employer's phone number_____
Responsible Part's name (if other than self)_____
Address_____ City_____ State_____Zip Code_____

Information about Your Health Insurance

Health/medical insurance company_____Agent's name_____
Name on policy (if other than self)_____ Policy no._____
Policyholder's name (f other than self or name on policy)_____

Information about Your Attorney

Name_____Phone_____ Agent's name_____
Address_____ City_____ State_____ Zip Code_____

Information about Your Vehicle Accident

1. Date of accident_____Time of accident_____
2. Your position in the vehicle: □ driver □front- seat passenger □back-seat passenger
3. Numbers of people in the vehicle_____, were you wearing your seat belts? □yes □no
4. Direction your vehicle was headed: □north □ south □east □ west
5. Direction other vehicle was headed: □north □south □east ☑west
6. Direction from which your vehicle was struck: □back □ front □left □right
7. Approximate speed of your vehicle:_____mph
   Approximate speed of other vehicle:_____mph
8. Were you knocked unconscious? □yes □no if yes, how long were you unconscious?_____
   _____
9. Were the police notified? □yes □no
10. Were there any witnesses to the accident? □yes □no
    If yes, please provide their names._____
    _____
11. In your own words, please describe the accident._____
    _____
    _____
    _____
12. Did you have any physical complaints BEFORE this accident? □yes □no
    If yes, please describe._____
    _____
    _____
13. Please describe how you felt:
    a. DURING this accident_____

b. IMMEDIATELY after this accident_____
c. LATER that same day_____
d. The NEXT day_____

14. What are your present complaints and symptoms _____

Do you have any congenital (i.e., from birth) factors that might relate to any of these problems?□yes □no

15. Do you have any illness that existed before the accident that might relate to this case? □ yes □no
If yes, please explain._____

16. Have you ever been involved in an accident before this one? □yes □no
If yes, please explain, including dates and types of accidents, as well as injuries received._____

17. Where were you taken after this accident occurred?_____
18. Have you been treated by another doctor since the accident? □yes □no
If yes, please provide doctors name._____
19. Since your accident occurred, have your symptoms □ Improved,□ Worsened, □or stayed the same
20. In the list below, mark every symptom you have noticed since the accident occurred:

□headache	□irritability	□numbness in toes	□upset stomach
□face flushing	□cold feet	□shortness of breath	□constipation
□neck pain	□fatigue	□fainting	□cold sweats
□neck stiffness	□dizziness	□depression	□fever
□sleeping problems	□head feeling heavy	□light sensitivity (eyes)	□cold hands
□back pain	□sensation of pins and needles in arms	□loss of memory	□diarrhea
□nervousness	□sensation of pins and needles in legs	□ringing in ears	□chest pain
□tension	□numbness in fingers	□buzzing in ears	
□loss of balance	□loss of sense of taste	□loss of sense of smell	

□Symptoms other than above (explain)_____

21. Have you lost time from work as a result of this accident □yes □no if so, please provide the following information.
a. Last day worked_____
b. Type of employment_____
c. Present salary_____
d. Are you being compensated for time lost from work □yes □no
If yes, what type of compensation are you receiving?_____
22. Do you notice any activity restrictions as a result of this injury? □yes □no if yes, please describe. _____
23. Other pertinent information_____

_____ _____

Date Patient's Signature

Check all that currently apply

Head
- □headaches
- □Sinus (allergy)
- □Back of head
- □Forehead
- □Temples
- □Migraine

□Head feeling heavy
□Loss of memory
□Light –headedness
□Fainting
□Light- sensitivity (eyes)
□Blurred vision
□Loss of vision
□Loss of sense of taste
□Loss of balance
□Dizziness
□Loss of hearing
□Ear pain
□Ringing in ears
□Buzzing in ears

Neck
□Neck pain
□Neck pain with movement
□Forward movement
□Backward movement
□Turn to left
□Turn to right
□Bend to left
□Bend to right
□Pinched nerve in the neck
□Neck feeling out of place
□Muscle spasms in neck
□Popping sounds in neck
□Arthritis in neck
□Grinding sound sin neck

Arms and Hands
□Upper-are pain
□Elbow pain
□Movement aggravated pain
Tennis elbow
□Forearm pain
□Hand pain
□Finger pain
□Sensation of pins and needles in arms
□sensation of pins and needles in fingers
□numbness in arms
- □right arm
- □ left arm

□fingers going to sleep
□cold hands
□swollen finger joints
□sore finger joints
□arthritis in fingers
□loss of grip strength

Shoulders
□shoulder-joint pain
- □right shoulder
- □ left shoulder

□pain across the shoulders
□bursitis
- □right shoulder
- □ left shoulder

□Arthritis
- □Right shoulder
- □ left shoulder

□inability to raise arm
- □ above shoulder level

□overhead
□shoulder tension
□pinched nerve in shoulder
- □right shoulder
- □ left shoulder
- □muscle-spasms in shoulder

Mid-Back
□Mid-back pain
location_____
□Pain between shoulder blades
- □sharp, stabbing pain
- □ Dull ache

□Pain from front to back
□Muscles spasms in mid-back
□Pain in kidney area

Low Back
□Low-back pain
- □upper lumbar
- □ lower lumbar
- □sacroiliac

□Low-back pain is worse when
- □working
- □lifting
- □stooping
- □standing
- □sitting
- □bending
- □coughing
- □lying down sleeping
- □walking

□Low- back pain is relieved when
_____
□Slipped disk
□low back feeling out of place
□muscle spasms in low back
□Arthritis in low back

Chest
□chest pain
□shortness of breath
□pain around ribs
□breast pain
□dimpled or orange-peel breast

Abdomen
□nervous stomach
□inability to eat certain foods
□nausea
□gas
□constipation
□diarrhea
□hemorrhoids

Hips, Legs, and Feet
□Buttock pain
□Hip- joint pain
□pain down legs
- □one
- □both

□knee pain
- □inside
- □outside

□Leg cramps
□ foot cramps
□ sensation of pins and needles in legs
□numbness in legs
□numbness in toes
□cold feet
□□swollen ankles
□swollen feet

□**WOMEN ONLY**
□menstrual cycle (days)_____
□menstrual pain where:_____
□cramping
□Irregularity
□birth control type:_____
□Hysterectomy
□Genital cancer
_____
□discharge
□menopause
□tumors
□abortions
□currently pregnant or could be

□**MEN ONLY**
□Urinary frequency
□difficulty starting urination
□night urination
□prostate pain/swelling

General
□nervousness
□irritability
□feeling depressed
□fatigue
□feeling generally rundown
□sleep:_____
□normal- hrs. /nights_____
□loss-hrs. /nights_____
□weight-loss- lbs._____
□diabetes
□hypoglycemia
□coffee consumption cups/day_____
□cigarette smoking packs/day_____
□OTHER_____

REMARKS

_____
_____
_____
_____

_____ _____
Patient's signature Date