1 Personal Information

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone Carrier: _____

Email: _____

Date of Birth: _____ Social Security #: _____

Gender (circle): Male Female

Occupation: _____ Employer: _____

Marital Status (circle): Single Married Widowed Separated Divorced

Spouse's Name: _____ Spouse's Phone Number: _____

Emergency Contact Name: _____ Relationship: _____

Phone: _____ Address: _____ City: _____ State: _____ Zip: _____

Whom may we thank for referring you? _____

2 Health Insurance Information

Person Responsible for Payment: _____ Relationship: _____

Are you insured? (circle) Yes No Insurance Company Name: _____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____

Member ID #: _____ Group #: _____

Is the patient covered by additional insurance? (circle) Yes No Insurance Company Name: _____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____

Member ID #: _____ Group #: _____

3 Accident Information

Is this condition due to an accident? (circle): Yes No

Type of Accident (circle): Auto Work Other: _____

To whom have you reported it? (circle): Auto Insurance Employer Police Other: _____

Date of Accident: _____ Attorney (if Applicable): _____

Name of Auto Insurance: _____ Claim #: _____

4 PAYMENT IS EXPECTED AT TIME OF VISIT

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. I understand that Peterson Chiropractic 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 directly to Peterson Chiropractic will be credited upon receipt, however, I clearly understand and agree that any services rendered to me are charge directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for services rendered me will be immediately due and payable.

Patient Signature: _____ Date: _____

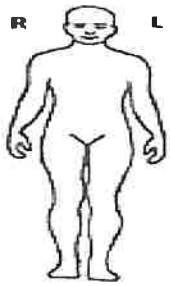
Guardian Signature: _____ Date: _____

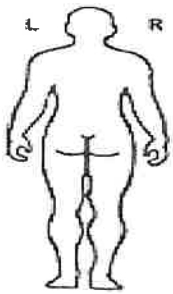
5 Patient Intake Form

Patient Name: _____ Date: _____

1. Is today's problem caused by: ◯ Auto Accident ◯ Worker's Comp ◯ Other

2. Indicate on the drawings to the right where you have pain/symptoms:





3. How often do you experience your symptoms:

◯ Constantly (76-100% of the time) ◯ Occasionally (26-50% of the time)
◯ Frequently (51-75% of the time) ◯ Intermittently (1-25% of the time)

4. How would you describe your pain?

◯ Sharp ◯ Dull ◯ Diffuse ◯ Electric-like w/ motion
◯ Achy ◯ Burning ◯ Shooting ◯ Shooting w/ motion
◯ Numb ◯ Tingly ◯ Stiff ◯ Sharp w/ motion

5. How are your symptoms changing with time?

◯ Getting Worse ◯ Staying the same ◯ Getting Better

6. From 0-10, 10 being the worst, how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

◯ Not at all ◯ A little ◯ Moderately ◯ Quite a bit ◯ Extremely

8. How much has the problem interfered with your social activities?

◯ Not at all ◯ A little ◯ Moderately ◯ Quite a bit ◯ Extremely

9. Who else have you seen for your problem?

◯ Chiropractor ◯ Neurologist ◯ Primary Care Physician
◯ ER physician ◯ Orthopedist ◯ No one
◯ Massage Therapist ◯ Physical Therapist ◯ Other: _____

10. How long have you had this problem? _____

11. How do you think your problem began? _____

12. Do you consider this problem to be severe? ◯ Yes ◯ Sometimes ◯ No

13. What aggravates your problem? (makes it worse) _____

14. What alleviates your problem? (makes it better) _____

15. What concerns you the most about your problem; what does it prevent you from doing? _____

16. What is your: Height: _____ Weight: _____ Date of Birth: _____

17. Occupation: _____ Have you missed work?: _____ How much?: _____

18. How would you describe your overall health?

◯ Excellent ◯ Very Good ◯ Good ◯ Poor

19. What type of exercise do you do?

◯ Strenuous ◯ Moderate ◯ Light ◯ None

20. Indicate if you have any immediate family members with any of the following:

◯ Rheumatoid Arthritis ◯ Diabetes ◯ Lupus
◯ Heart Problems ◯ Cancer ◯ ALS (Lou Gehrig's Disease)

21. List all medications you are currently taking including over-the-counter medication: _____

_____

22. List all surgical procedures you have had: _____

23. What activities do you do outside of work?: _____

24. Have you ever been hospitalized? _____ If yes, why? _____

25. Have you had significant past trauma? _____

26. Have you previously seen a chiropractor? _____ If yes, why? _____

27. Anything else pertinent to your visit today? _____

Patient Signature: _____ Date: _____

6 Auto Accident History

Patient Name: _____ Date: _____ Accident Date: _____

Accident Location: _____ Accident Time: _____ AM / PM

How did the accident occur?: _____

_____

Were you the: ◯ Driver ◯ Passenger ◯ Front ◯ Rear ◯ Right ◯ Left

At the time of impact was your car: ◯ Stopped ◯ Slowing Down ◯ Gaining Speed ◯ Steady

Were you aware of the impending collision?: ◯ Yes ◯ No

Were you wearing a seat belt: ◯ Yes ☐ No ◯ Shoulder/lap ◯ Lap only

Did the seat belt injure you?: ◯ Yes ◯ No

If yes, describe: _____

Road conditions at the time: ◯ Wet ◯ Dry ◯ Icy

At the time of the collision, were you looking: ◯ Forward ◯ Down ◯ Right ◯ Left

How were you thrown?: _____

Did any body part hit the car interior?: ◯ Yes ◯ No

If yes, describe: _____

Did you lose consciousness? (black out): ◯ Yes ◯ No For how long?: _____

Did you experience: ◯ Confusion ◯ Disoriented ◯ Dizzy ◯ Blurred Vision ◯ Ringing in ears ◯ Nausea

What symptoms did you have at the scene?: _____

_____

Vehicle you were in: Year: _____ Make: _____ Model: _____

Describe damage: _____ Estimate: $_____

Other vehicle: Year: _____ Make: _____ Model: _____

Describe damage: _____ Estimate: $ _____

Who was given a citation? ◯ No one ◯ You ◯ Other Driver

After the accident did you go: ◯ Hospital ◯ Home ◯ Other _____

By: ◯ Ambulance ◯ Your vehicle ◯ Other _____

Treatment Given: _____

Your Job Title: _____

Lost time from work?: ◯ Yes ◯ No How much?: _____

Have you ever had similar problems?: ◯ Yes ◯ No

If yes, describe: _____

_____