How has this condition affected your life?

_____

Is there anything you do that makes your condition worse? _____

_____

How has this condition affected your life?

A. Home life _____
B. Occupational life _____
C. Recreational life _____
D. Rest and Sleep life _____

Have you ever been in an automotive accident? ☐ Past year ☐ Past 5 years ☐ Over5years ☐ Never

ANY ACCIDENTS, FALLS, ETC, THAT MIGHT HAVE CAUSED YOUR PROBLEM _____

_____

What surgery has been done? _____

Are you pregnant? ☐ Yes ☐ No

DRUGS YOU NOW TAKE: ☐ Nerve Pills ☐ Pain Killers ☐ Muscle Relaxers ☐ "Pep" Pills ☐ Tranquilizers
☐ Birth Control Pills ☐ Other (please list) _____

ANY CHIROPRACTOR CONSULTED IN THE PAST? Name: _____

Dates Consulted: _____ For what problem? _____

Fees are payable at the time X-rays, examinations, and treatments are received, unless other arrangements are made In advance. X-rays remain the property of this clinic.

Patient's Signature _____ Social Security No: _____ Date _____

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING QUESTIONS

Date of Accident: _____ Hour: _____Am _____PM Location: _____

How did accident occur? ☐ Auto Collision ☐ On-the-Job Injury ☐ Other _____

Did you go to the hospital? ☐ Yes ☐ No ☐ By Ambulance ☐ Or Drive

Did you call your insurance company and do you have a claim number? _____

Of auto accident, were you ☐ Driver? ☐ Passenger? ☐ Pedestrian?

If auto collision, were you struck from ☐ Behind? ☐ Right side? ☐ Left Side? ☐ Front? ☐ Auto was parked

Did your car strike the other(s) involved? ☐ Yes ☐ No; Or did the other car strike yours? ☐ Yes ☐ No ☐ Undetermined

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headache	☐ Irritability	☐ Numbness in toes	☐ Face Flushed	☐ Feel Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head seems too heavy	☐ Depression	☐ Fainting Spells	☐ Constipation
☐ Back Pain	☐ Pins and Needles in Arms	☐ Light bothers Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins and Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ _____

Symptoms other than above: _____

Have you lost any days of work? ☐ Yes ☐ No Dates: _____

Name of Your Insurance Involved: _____

Name of Insurance Company or person responsible for injuries: _____

Have you been contacted by an Insurance Adjuster or Company Representative regarding this claim? ☐ Yes ☐ No

Do you have an attorney who has advised you in this case? ☐ Yes ☐ No Name: _____

Address of attorney: _____ Phone No: _____