PATIENT APPLICATION FOR CARE

Patient Information

Name _____
Address _____
City _____State_____Zip _____
Home Phone_____Height _____
Cell Phone _____Weight_____
Soc. Sec. No. _____
Date of Birth _____Age_____
Email _____
Employer _____
Business Phone_____
Occupation _____
Marital Status: M S W D # Children_____
Spouse's Name _____

Guarantor Information If Other Than Patient

Name _____
Address _____
City _____State _____Zip_____
Home Phone _____
Soc. Sec. No._____
Date of Birth _____
Employer _____
Business Phone _____
Occupation_____
Marital Status: M S W D # Children_____
Spouse's Name_____

Who referred you to our office? _____

- -

INSURANCE INFORMATION: Please Check which applies: Work____ Auto Accident____ Other____

Primary Carrier_____
Address_____
City _____State_____Zip_____
Phone No._____
Policy _____Group_____
Enrollee_____Birthday_____
Soc. Sec. No._____

Secondary Carrier _____
Address _____
City_____State_____Zip_____
Phone No._____
Policy _____Group_____
Enrollee _____Birthday_____
Soc. Sec. No. _____

- -

WHAT IS YOUR HEALTH PHILOSOPHY? _____

HOW DO YOU WANT US TO HANDLE YOUR PROBLEM? Maximum Correction_____ Temporary Relief _____

WHAT ARE YOUR EXPECTATIONS OF US?_____

X-RAY CONFIRMATION: I consent to spinalgraphic x-rays. I understand that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant.

PATIENT SIGNATURE_____**DATE**_____

Are you Right or Left handed?

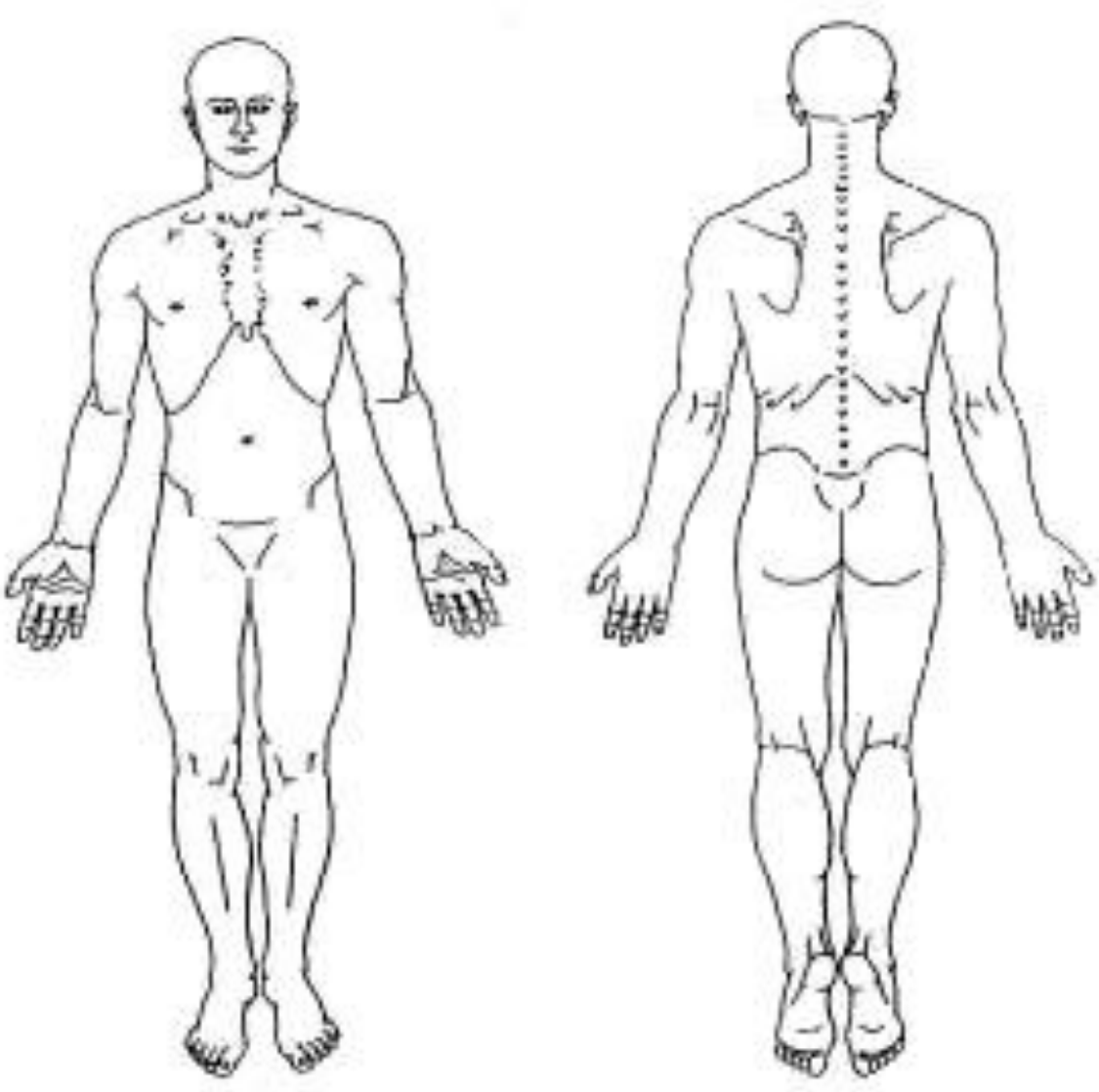
Fees are payable when services received unless special arrangements are made in advance.

Hales Chiropractic Center - 360 S. State St. Suite-A - Clearfield, UT 84015 - 801-773-1821

PATIENT APPLICATION FOR CARE

Draw your areas of pain on the pictures by using the following letters below:

M =Mild **X** =Moderate **S** =Severe **N** =Numb



The above information is true and accurate to the best of my knowledge:

Signature: _____ Date: _____

Motor Vehicle Collision - Mechanism of Injury

Name: _____ Today's Date: _____

Date of Collision: _____ Hour of Accident: _____ AM / PM

Please describe how the collision happened: _____

_____

_____

_____

_____

1. What type and year of vehicle were you in? _____
2. What type and year of vehicle struck yours? _____
3. What was your position in the car? **Driver** / **Front Passenger** / **Left Rear** / **Right Rear**
   a. If "Driver", were your hands on the steering wheel? **Both** / **Left only** / **Right only**
4. Were you wearing a seatbelt? **Yes** / **No** What type: **Lap Belt** / **Shoulder Belt** / **Both**
5. Did the airbags deploy? **Yes / No**
6. Where was your head facing at the time of impact? **Left** / **Right** / **Straight Ahead** / **Inclined / Down**
7. Were you rendered unconscious as a result of the accident? **Yes / No**
8. Direction of Impact: **Front** / **Back** / **Left** / **Right** / **Other**: _____
9. Was your vehicle towed from the scene? **Yes / No**
10. How would you describe the impact; how did it feel? **Mild / Moderate / Severe**
11. 2nd Collision: After the first impact, did <u>you strike</u> another vehicle? **Yes** / **No**
    a. If "YES", after the first impact, did a 2nd vehicle <u>strike your</u> vehicle? **Yes** / **No**
    b. *If 2nd Collision – Angle of 2nd impact: **Front** / **Back** / **Left** / **Right** / **Other**: _____
12. In relation to the back of your head, was your headrest set: **Low** / **Middle** / **High**
13. Were you surprised by the impact? **Yes** / **No.** If "NO", how did you brace? w/**Hands** / w/**Feet**
14. Did you feel pain immediately after the accident? **Yes** / **No**
    a. Where and how bad? _____
    b. How did the pain feel? **Achy, Deep, Sharp, Stabbing, Throbbing, Piercing, Other**_____
15. Did your seat break or bend? **Yes / No**
16. Did you strike anything in the vehicle at the time of impact? **Yes** / **No** If "YES", specify what part of your body struck what part of the car below: (i.e. head, chest, chin, shoulder, knee, etc.)

EXAMPLE : →	-Airbag "face and chest"	-Door "left shoulder"

-Airbag	-Door	-Seat
-Armrest	-Flying object(s) inside vehicle	-Steering wheel
-Center console	-Headrest	-Window
-Dashboard	-Roof	-Other occupant
-Other		

17. Did you receive any: **Cuts or Bruises**? (circle and describe): Where? _____

_____

_____

Motor Vehicle Collision - Mechanism of Injury

Any additional symptoms at the time of the accident? (Circle all that apply)

-Anxiety	-Exhaustion	-Chest pain	-Depressing	-Dizziness	-Breathing difficulty
-Facial pain	-Genital pain	-Gluteal pain	-Headaches	-Irritability	-Loss of appetite
-Low energy	-Muscle spasm	-Rib pain	-Shock	-Soreness	-Sleeping difficulty
-Stomach pain	-Stress	-Stunned	-Tightness	-Tiredness	-Numbness or Tingling
-Upset	-Other_____				

Since the Motor Vehicle Collision, what is the status of your symptoms/complaints?

-More pain	-Less pain
-More stiffness	-Less stiffness
-Deteriorated daily function at work/home	-Shown no change in daily function at work/home
-Worsened quality of life	-Stayed the same

Since the Motor Vehicle Collision, have you experienced any of the following?

A.	Loss of Range of Motion	yes/no	What body parts: _____
B.	Visual Disturbance	yes/no	(please explain):_____
C.	Dizziness	yes/no	How often: _____
D.	Anxiety	yes/no	How often: _____
E.	Depression	yes/no	How often: _____
F.	Difficulty Sleeping	yes/no	How often: _____

Police and Ambulance

Was the accident reported to the police? **Yes** / **No**

Were traffic citations issued? **Yes** / **No** If "YES", to whom? _____

Did EMS (Ambulance or Paramedic) arrive at the scene? _____

Did you go to the hospital? **Yes** / **No** If "YES", when? _____

A- If "YES", how did you get there? **Ambulance** / **Police Car** / **Private Transportation**

B- Were you admitted? **Yes** / **No** If "YES", how long? _____

C- Name of Hospital? _____

D- What treatment was given? (Circle all that apply)

-None	-Muscle relaxers	-Instructed regarding concussion
-X-rays	-Cervical collar	-Instructed regarding sprains & strains
-Stitches	-Physical therapy	-Instructed to call an orthopedist
-Bandaged	-Referred to this office	-Instructed to call a private physician
-Pain medication	-Other: _____	

Have you had any other treatments as a result of this injury? _____

Symptoms other than any of the above: _____

_____

The above information is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

AUTO ACCIDENT - PATIENT SYMPTOM FORM

Patient Name: _____

1. Where is the MAIN problem/symptom you are having? (one area, example: neck): _____

On a scale from 0-10, with 10 being the worst, please circle the number that best describes the **pain** most of the time: 0 1 2 3 4 5 6 7 8 9 10 Key: 0 = No pain at all 10 = Pain as bad as it could be (i.e. Call 911)	Circle the **one** that **best** describes how often you have your pain: 1. All of the time (constant) 2. Most of the time (near constant) 3. A good bit of the time (3-4 days/week) 4. Some of the time (less than 3 days/week) 5. A little of the time (1 day/week) 6. Hardly any of the time (less than 4 days/month) 7. None of the time

- Describe the quality of this pain or discomfort (circle all that apply):
  - achy, annoying, burning, deep, diffuse, dull, heavy, intolerable, pulling, sharp, shock like, stabbing, stiffness, throbbing, tightness, tingling, numbness, other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): YES or NO
  - If YES, where does the symptom radiate? _____
- Is your symptom getting: better - worse - staying the same (circle one)
- What makes the symptom better? _____
  _____
- What makes the symptom worse? _____
  _____
- Did you have this symptom before this accident? Yes or No
  - If YES, date of last occurrence: _____
  - If YES, what was the intensity, **1-10 (**10= the worst) _____, and how often did you have the pain (1-7):_____
- Any previous treatment for this problem? YES or NO If YES, what kind? _____

2. Where is the next most bothersome problem/symptom you are having? _____

On a scale from 0-10, with 10 being the worst, please circle the number that best describes the **pain** most of the time: 0 1 2 3 4 5 6 7 8 9 10 Key: 0 = No pain at all 10 = Pain as bad as it could be (i.e. Call 911)	Circle the **one** that **best** describes how often you have your pain: 1. All of the time (constant) 2. Most of the time (near constant) 3. A good bit of the time (3-4 days/week) 4. Some of the time (less than 3 days/week) 5. A little of the time (1 day/week) 6. Hardly any of the time (less than 4 days/month) 7. None of the time

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  - achy, annoying, burning, deep, diffuse, dull, heavy, intolerable, pulling, sharp, shock like, stabbing, stiffness, throbbing, tightness, tingling, numbness, other (please describe): _____
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  - If YES, where does the symptom radiate? _____
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- What makes the symptom better? _____
  _____
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  _____
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  - If YES, date of last occurrence: _____
  - If YES, what was the intensity, **1-10 (**10= the worst) _____, and how often did you have the pain (1-7):_____
- Any previous treatment for this problem? YES or NO If YES, what kind? _____

Signature: _____ Date: _____

3. Where is the <u>next most bothersome</u> problem/symptom you are having? _____

On a scale from 0-10, with 10 being the worst, please <u>circle the number</u> that best describes the **pain** most of the time:	Circle the **one** that **best** describes how often you have your pain:
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	5. A little of the time (1 day/week)
	6. Hardly any of the time (less than 4 days/month)
	7. None of the time

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- Did you have this symptom <u>before this accident</u>? Yes or No
  - <u>If YES</u>, date of last occurrence: _____
  - <u>If YES</u>, what was the intensity, **1-10 (**10= the worst) _____, and how often did you have the pain (1-7):_____
- Any previous treatment for this problem? YES or NO <u>If YES</u>, what kind? _____

4. Where is the <u>next most bothersome</u> problem/symptom you are having? _____

On a scale from 0-10, with 10 being the worst, please <u>circle the number</u> that best describes the **pain** most of the time:	Circle the **one** that **best** describes how often you have your pain:
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- Is your symptom getting: better - worse - staying the same (circle one)
- What makes the symptom better? _____
  _____
- What makes the symptom worse? _____
  _____
- Did you have this symptom <u>before this accident</u>? Yes or No
  - <u>If YES</u>, date of last occurrence: _____
  - <u>If YES</u>, what was the intensity, **1-10 (**10= the worst) _____, and how often did you have the pain (1-7):_____
- Any previous treatment for this problem? YES or NO <u>If YES</u>, what kind? _____

Signature: _____ Date: _____

Daily Activities Assessment

1. Which activities of daily living are being most affected, since the accident?

Circle all that apply:

-Employment
-Homemaking
-Lifting
-Personal care (washing, dressing, etc.)
-Sitting
-Sleeping
-Social life
-Standing
-Traveling and/or driving
-Walking
-Other: _____

2. Which do you have difficulty performing now, since the accident?

Circle all that apply:

-Bending over
-Caring for family
-Climbing stairs
-Concentrating
-Dressing self
-Driving car
-Exercising
-Getting in/out of car
-Getting to sleep
-Grocery shopping
-Performing household chores
-Lifting objects
-Looking over shoulder
-Making love
-Lying down
-Reaching overhead
-Rising out of chair or bed
-Showering or bathing
-Sitting
-Standing
-Staying asleep
-Walking
-Participating in yard work
-Other_____

2. What are your specific goals for care?

Circle all that apply:

-To have no functional limitations
-To decrease stiffness
-To sleep throughout the night w/o pain
-To relieve pain
-To decrease swelling
-To walk on all terrain w/o limitation
-To improve all ranges of motion w/o pain
-To be able to hunt w/o limitation
-To be able to life w/o pain
-To return to sport activity w/o limitation
-To improve strength
-To return to work w/o limitation
-To improve flexibility
-To walk without need of assistance

Signature:_____ Date: _____