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?

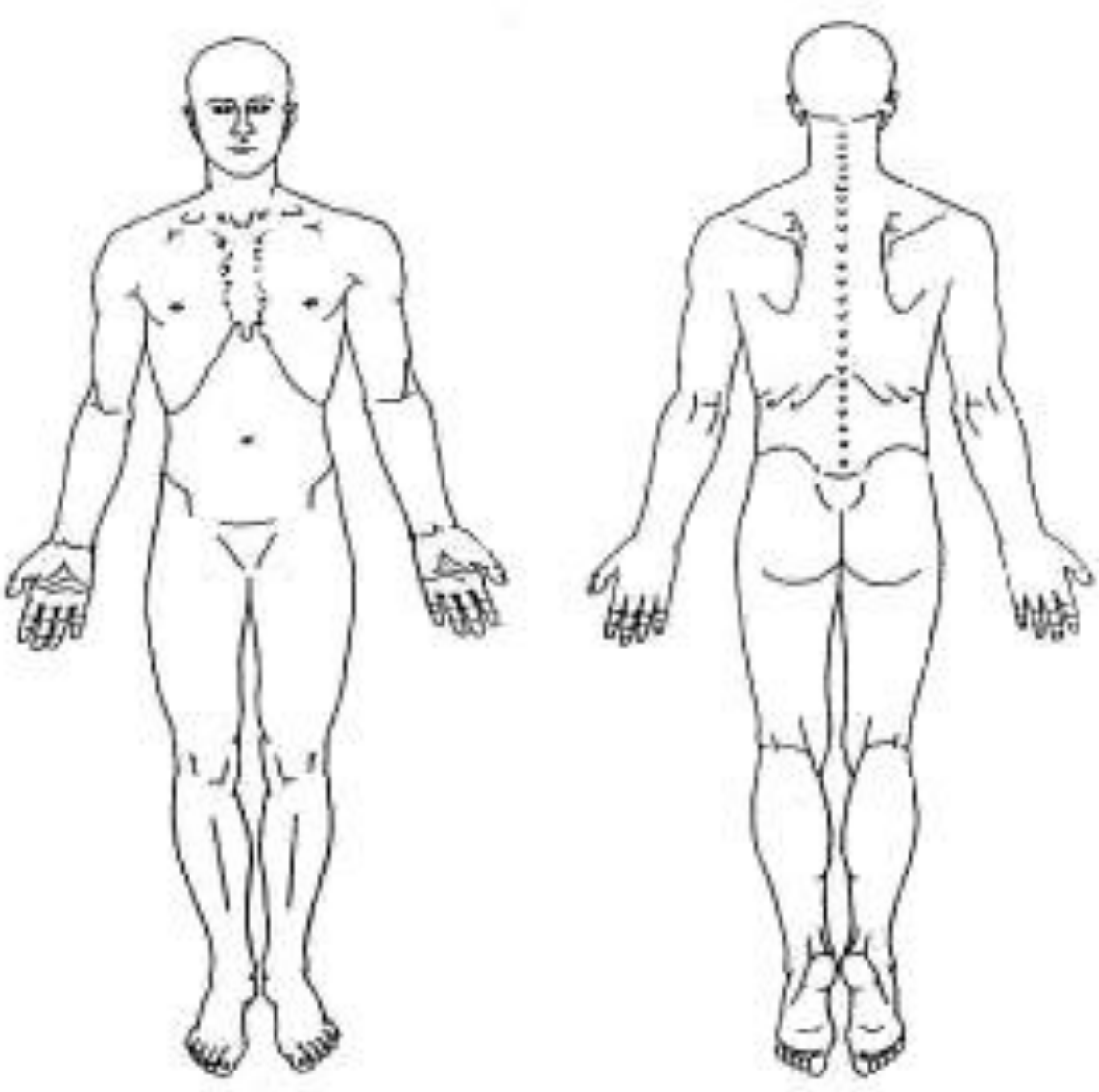
Fees are payable when services received unless special arrangements are made in advance.

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

Did you receive any: **Cuts or Bruises**? (circle and describe below):

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

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

B- If "NO", how did you get home/work after the accident? _____

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

D- Name of Hospital? _____ Attended by Dr. _____

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

-None	**-Muscle relaxants**	**-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:** _____	

What other doctor have you seen as a result of this injury? _____

Do you have difficulty in excessive: **Standing** / **Walking** / **Riding** / **Bending** / **Twisting**

Do you have difficulty in excessive lifting: **Light** / **Moderate** / **Heavy** / **Repetitive**

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: _____ Date: _____

1. What/Where is the <u>MAIN</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:
0 1 2 3 4 5 6 7 8 9 10	1. All of the time (constant)
Key:	2. Most of the time (near constant)
0 = No pain at all	3. A good bit of the time (3-4 days/week)
10 = Pain as bad as it could be (i.e. Call 911)	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

- When did the symptom begin? _____ Did the symptom begin: -suddenly or -gradually?
  - Did you have this symptom <u>before this accident</u>? Yes / No 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):_____
- What makes the symptom worse? _____
  _____
- What makes the symptom better? _____
  _____
- Describe the quality of the symptom (circle all that apply):
  - achy, annoying, burning, deep, diffuse, dull, heavy, intolerable, pulling, sharp, shock like, stabbing, stiffness, throbbing, tightness, tingling, other (please describe): _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____

2. What/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:
0 1 2 3 4 5 6 7 8 9 10	1. All of the time (constant)
Key:	2. Most of the time (near constant)
0 = No pain at all	3. A good bit of the time (3-4 days/week)
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- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____

3. What/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: 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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  - Did you have this symptom <u>before this accident</u>? Yes / No Date of last occurrence: _____
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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: 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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  - If yes, where does the symptom radiate? _____

Signature: _____ Date: _____

Daily Activities Assessment

Please answer the questions below that best describe how you are currently feeling and being effected by your injuries.

1. What activity of daily living has been 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. What 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_____

Signature:_____ Date: _____