NCRC Nelson Clinic and Rehabilitation Care

Accident/Injury Forms

PLEASE FILL OUT COMPLETELY- PLEASE PRINT

PERSONAL INFORMATION

Name (First)_______________________________ (MI)_____ (Last)____________________________________

Address ____City ______________State ________ Zip _________

Home Phone # ________________________ Cell Phone # _____________________ Work # ________________

Date of Birth _________________ Age _______ Gender ☐ Male ☐Female Marital Status : M S W D

Social Security Number ___________________ Email _____________________________ No. of Children? _____

Occupation __________________________________ Employer _______________________________________

Address ____City ______________State ________ Zip _________

Spouse's Name ________________________Occupation ____________________Employer________________

Emergency Contact ________________________________ Relationship to Patient __________________________

Address ____City ______________Phone # ________________

CURRENT PRIMARY HEALTH CONCERN

What is your main symptom? ____

How long have you had this condition? ____

Have you had this or similar conditions in the past? ☐ Yes ☐ No When?______________________________

What seemed to have caused this condition? ____

What position(s), if any, make it feel worse? ____

What position(s), if any, make it feel better? ____

Over time, is this condition: ☐ Improving ☐ Unchanged ☐ Getting Worse?

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other:_________________________

Average pain intensity:

Last 24 hours: **no pain** ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ **worst pain**

Past week: **no pain** ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ **worst pain**

How often do you experience your symptoms?

① Constantly (75-100% of the time) ② Frequently (50-75%) ③ Occasionally (25-50%) ④ Intermittently (0-25%)

How much have your symptoms interfered with your usual daily activities?

① Constantly (75-100% of the time) ② Frequently (50-75%) ③ Occasionally (25-50%) ④ Intermittently (0-25%)

In general, would you say your overall health right now is…

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

Have you sought advice or treatment from other doctors or therapist for *this* condition? ☐ Yes ☐ No

Have you ever been seen by a Doctor of Chiropractic before? ☐ Yes ☐ No If so, when? _______________

Who is your family medical doctor? ________________________________ Location: _______________________

ACCIDENT INFORMATION

Date of Accident ____________________ Hour____________ AM / PM Location______________________________

How did Accident Occur? ☐ Auto Collision ☐ On-the-job Injury ☐ Other

If not an auto collision, please describe the circumstances: ____

____

On-the-job Injury:

Did you report the injury to your foreman or employer? ☐ Yes ☐ No

Did they recommend care at our office? ☐ Yes ☐ No

Did you require post-accident hospitalization? ☐ Yes ☐ No

Have you lost any days of work? ☐ Yes ☐ No Dates______________________________________

Auto Collision:

If 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

Did the other car strike yours? ☐ Undetermined ☐ Yes ☐ No

As a result of the accident were traffic citations issued to you? ☐ Yes ☐ No

To the driver of the other car? ☐ Yes ☐ No

To the driver of your car? ☐ Yes ☐ No

List the extent of the injuries as you know them:

____

____

Did you require post- accident hospitalization? ☐ Yes ☐ No

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

REVIEW OF SYSTEMS

Have you ever suffered from: *Please check all that apply.*

General:
☐ Weight loss or gain
☐ Fatigue
☐ Fever or chills
☐ Weakness
☐ Trouble sleeping

Skin:
☐ Rashes
☐ Lumps
☐ Itching
☐ Dryness
☐ Color changes
☐ Hair & nail changes

Head:
☐ Headache
☐ Head injury

Eyes:
☐ Pain
☐ Redness
☐ Blurry or double vision
☐ Visual disturbances
☐ Glaucoma
☐ Cataracts

Ears:
☐ Decreased hearing
☐ Ringing in ears
☐ Earache
☐ Drainage

Nose:
☐ Chronic discharge
☐ Itching
☐ Hay fever
☐ Chronic nosebleeds
☐ Sinus pain

Throat:
☐ Bleeding
☐ Dentures
☐ Soreness
☐ Hoarseness
☐ Thrush
☐ Non-healing sores

Neck:
☐ Lumps
☐ Swollen glands
☐ Pain
☐ Stiffness

Breasts:
☐ Lumps
☐ Pain
☐ Discharge
☐ Breast Feeding

Respiratory:
☐ Cough
☐ Sputum
☐ Coughing up blood
☐ Shortness of breath
☐ Wheezing
☐ Painful breathing

Cardiovascular:
☐ Chest pain
☐ Tightness
☐ Palpitations
☐ Shortness of breath
☐ Difficulty breathing
☐ Swelling
☐ Sudden awakening of sleep from shortness of breath

Gastrointestinal:
☐ Swallowing difficulties
☐ Heartburn
☐ Change in appetite
☐ Nausea
☐ Change in bowel habits
☐ Rectal bleeding
☐ Constipation
☐ Diarrhea
☐ Yellow eyes or skin

Urinary:
☐ Frequency
☐ Urgency
☐ Burning or pain
☐ Blood in urine
☐ Incontinence
☐ Change in strength

Vascular:
☐ Calf pain with walking
☐ Leg cramping

Hematologic:
☐ Ease of bruising
☐ Ease of bleeding

Neurologic:
☐ Dizziness
☐ Fainting
☐ Seizures
☐ Numbness
☐ Tingling
☐ Tremor

Endocrine:
☐ Head or cold intolerance
☐ Sweating
☐ Thirst

Psychiatric:
☐ Nervousness
☐ Stress
☐ Depression
☐ Memory loss

OTHER HEALTH COMPLAINTS or CONCERNS

☐ Ulcers/ Colitis
☐ Heart Attack/Stroke
☐ Thyroid Problems
☐ Kidney Problems
☐ Hepatitis
☐ Cancer
☐ Venereal Disease
☐ Congenital Heart Defect
☐ Heart Surgery/ Pacemaker
☐ High/Low Blood Pressure
☐ Asthma
☐ Arthritis
☐ Alcohol/ Drug Abuse
☐ Diabetes
☐ Shingles
☐ Chemotherapy
☐ Anemia
☐ Rheumatic Fever
☐ HIV/ AIDS

For Women Only:

Are you pregnant? ☐ Yes ☐ No Are you Nursing? ☐ Yes ☐ No Are you taking birth control? ☐ Yes ☐ No

Experience painful periods? ☐ Yes ☐ No Have Irregular cycles? ☐ Yes ☐ No Breast Implants? ☐ Yes ☐ No

FAMILY HISTORY

Do you have a family history of any of the following:
(Check all that apply)

If so, describe: ______________________________________
____

☐ Heart Disease/Stroke
☐ Congenital Heart Defect
☐ Heart Surgery/ Pacemaker
☐ Kidney Problems
☐ Cancer
☐ Thyroid Problems
☐ Hepatitis
☐ High/Low Blood Pressure
☐ Arthritis
☐ Breathing Problems

SOCIAL HISTORY

Stress level: ☐ High ☐ Moderate ☐ Low Main source of stress: ______________________

Physical Work: ☐ Heavy ☐ Moderate ☐ Light

Exercise: ☐ Heavy ☐ Moderate ☐ Light ☐None

Smoking: ☐ Never ☐ Currently ☐ Previously How long? _________ Packs/Day:_________

Alcohol: ☐ Never ☐ Occasional ☐ Weekly ☐ Daily

MEDICAL HISTORY

Please list all surgeries/hospitalizations: ☐ None Date:

____
____
____

Please list all accidents/falls/injuries: ☐ None Date:

____
____
____

Medications: ☐ None Please list name and purpose: ______________________________
____
____

Doctor's Notes: ______________________________________
____
____
____

INSURANCE INFORMATION

My Company:________________________________ Claim #: _______________________________

Agent: _____________________________________Phone Number: ___________________________

Address: _______________________________ City: ______________ State: ________ Zip: _______

Company of person responsible for injuries: ____

Have you contacted an insurance adjuster or company representative regarding this claim? ☐ Yes ☐ No

Do you have an attorney that has advised you in this case? ☐ Yes ☐ No

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Donner Family 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 Donner Family Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

Patient Signature: ____ Date: ___________________

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he deems appropriate. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance right and benefits (if applicable) directly to the provider of services rendered.

______________________________ __________ ____________________________ ________

Patient Signature Date Guardian or Spouse's Signature Date