New Patient History

Oliver Chiropractic

ABOUT YOU

Last Name:	First Name:	Middle:
Age Date of Birth:	Male Female	Single Married Separated Divorced Widowed
Spouse's Name:	Spouse's Occupation:	
Do you have children? Yes / No How many?	Your Weight:	Your Height:
Social Security Number: - -	Drivers License #	
Home Address	City	State Zip
Home phone #:	Other phone #:	
E-mail address	Work phone #:	
Occupation:	Employer:	

IN EVENT OF EMERGENCY

Who should we contact?	Relation:
Home Phone #:	Work Phone #:

CLAIM INFORMATION

Date of Accident: Time of accident: City/State:

Did you sustain injury? Yes No Have you filed a claim or communicate with any Insurance Company? Yes No

Your Insurance Company:

Telephone: Claim Number: Adjustor Name:

Other Person's Insurance Company:

Telephone: Claim Number: Adjustor Name:

Were the police at the scene of the accident? Yes No

Police Report? Yes No

Are you represented by an Attorney? Yes No

Name:

ACCIDENT INFORMATION

Were you the: [ ] Driver [ ] Passenger
[ ] Front seat [ ] Back seat

Accident happened on: [ ] Interstate [ ] Highway [ ] Street [ ] Intersection [ ] other

Your vehicle was traveling: [ ] North [ ] South [ ] East [ ] West
Name of Street/Highway: ______________________________
Intersection:

Other vehicle was traveling: [ ] North [ ] South [ ] East [ ] West
Name of Street/Highway: ______________________________
Intersection:

Your vehicle was struck/hit: [ ] From behind [ ] In front
[ ] Rear panel [ ] Front panel
[ ] Driver's side [ ] Passenger side
[ ] Multiple Impacts [ ] Single Collision

Please, describe in detail how the accident happened:

Were you wearing seat belts/restraints: Yes No **Did air bags deploy?** Yes No

As best as you can recall, did you strike anything inside the interior of the auto?

[ ] Nothing [ ] Gear Shift [ ] Front Windshield
[ ] Dashboard [ ] Headrest [ ] Rear Window
[ ] Side Window [ ] Door Panel [ ] Armrest
[ ] Steering Wheel [ ] Window Frame [ ] Other

How soon after the accident did you feel pain or symptoms?

[ ] Immediately after the accident. [ ] Days after the accident.
[ ] Rapidly within one hour after the accident. [ ] Weeks after the accident.
[ ] Gradually with 23 hours after the accident.

Did you experience any of the following after the collision or impact? Circle all that apply.

Felt Normal Unconscious Dazed Dizziness Confused
Nausea Cuts/Lacerations Abrasions Bruises / Contusions

Where did you go after the accident? Home Work Emergency Room Other

Please describe damage done to the vehicle that *you* were driving or riding:

Make and model of your vehicle: Year

Please describe damage done to the other vehicle:

Make and model of your vehicle: Year

Initial Treatment

Have you receive any examination for these injuries/complaints? Yes No If yes, where?

[ ] Emergency Room [ ] Urgent Care Facility [ ] Family Physician [ ] Other

What procedures were performed? [ ] Examination [ ] X-rays [ ] CT Scan [ ] MRI Scan

What was the Diagnosis?

What treatment was provided? Stitches Injections Prescribed Medication

What medications were prescribed?

Have you attended any additional office visits or treatment? Yes No If yes, where?

Family Physician Physical Therapy Chiropractic Care Specialist

Current Complaints and Symptoms

Please check all of the following that describes your current problem(s):

[ ] Headaches
[ ] Migraines
[ ] Neck Pain / Stiffness
[ ] Shoulder Pain / Stiffness
[ ] Wrist / Hand Pain or Stiffness
[ ] Upper Back Pain or Stiffness
[ ] Mid Back Pain or Stiffness
[ ] Low Back Pain or Stiffness
[ ] Hip Pain or Stiffness
[ ] Knee Pain or Stiffness
[ ] Ankle/Foot Pain or Stiffness
[ ] Pain w/ coughing
[ ] Pain shooting down leg(s)
[ ] Pain w/ sneezing
[ ] Painful Joints
[ ] Pain shooting down arms(s)
[ ] Numbness

What is the most painful or troublesome condition(s) causing you to consult our office today?

What activities are painful?

[ ] Neck Movement
[ ] Back Movement
[ ] Sitting
[ ] Driving
[ ] Walking
[ ] Standing
[ ] Housework
[ ] Bending and Stooping
[ ] Lifting
[ ] Pushing & Pulling
[ ] Overhead work
[ ] Desk Work

What describes the nature of your complaint(s)?

[ ] Sharp
[ ] Tingling
[ ] Dull Ache
[ ] Numbness
[ ] Shooting
[ ] Burning
[ ] Sore
[ ] Weakness
[ ] Tightness
[ ] Restricted movement
[ ] Muscle Spasms

When are your symptoms worse or most intense?

[ ] Morning
[ ] Afternoon
[ ] Evening
[ ] Late night
[ ] After activities
[ ] After rest
[ ] At Work
[ ] In Bed

Current Complaints and Symptoms (cont'd)

What make your symptoms feel better? [ ] Nothing [ ] Rest [ ] Stretching [ ] Over the counter medication [ ] Prescription medication [ ] Activity / Exercise [ ] Therapy	**What home therapy have you tried?** [ ] Nothing [ ] Heat [ ] Cold [ ] Rest [ ] Stretching [ ] Activity / Exercise [ ] Ointments / Rubs [ ] Heat Patches	**How is your sleep?** [ ] Normal [ ] Mildly Fragmented [ ] Very Fragmented [ ] Poor – little sleep **How is your appetite?** [ ] Normal [ ] Poor
How are your symptoms changing? [ ] Getting Better [ ] Not Changing [ ] Getting Worse	**Have you missed any work due to injury/pain?** [ ] No [ ] Yes How many days/weeks? ________ Date last worked: ___________________	**Can you perform your usual daily activities?** [ ] No [ ] Yes **Can you perform your usual work activities?** [ ] No [ ] Yes

Past Injuries

Have you been involved in any prior auto accidents? [ ] No [ ] Yes

If yes, how many? Date of last auto accident:

Did you sustain any injuries? [ ] No [ ] Yes

Was treatment required? [ ] No [ ] Yes

Treatment Received:

Did you recover completely: [ ] No [ ] Yes

Have you ever sustained any injury while working? [ ] No [ ] Yes

Date of last work comp injury? Area(s) of injury:

Was treatment required? [ ] No [ ] Yes Did you recover completely? [ ] No [ ] Yes

Treatment Received:

Have you ever sustained any prior injury to your Neck, Back, or Spine? [ ] No [ ] Yes
(please circle)

Was treatment required: [ ] No [ ] Yes Did you recover completely? [ ] No [ ] Yes

Treatment Received:

Have you ever sustained any past injury to your Shoulder, Arms, Hands, Hips, Leg or Feet? [ ] No [ ] Yes
(please circle)

Any fractures? [ ] No [ ] Yes Did you recover completely? [ ] No [ ] Yes

Was treatment required? [ ] No [ ] Yes

Treatment Received:

Medical History

Please list past surgeries: [ ] None

Date(s): Medical Condition:

Have you ever been hospitalized for medical illness or injury? [ ] No [ ] Yes

Dates: Medical Condition:

Do you have a regular family physician or primary care provider? [ ] No [ ] Yes
Are you currently under medical care or monitoring for a condition? [ ] No [ ] Yes
Name: Date of Last Visit:

For women only: Are you pregnant? [ ] No [ ] Yes

List current medical condition(s): [ ] None

Have you required any past medical care /evaluation for the following conditions? [ ] None
[ ] Diabetes [ ] High Blood Pressure [ ] Cancer/Tumor [ ] Arthritis [ ] Migraine Headaches
[ ] Heart Attack [ ] Stroke [ ] Seizures [ ] Stomach problems [ ] Asthma/Emphysema
[ ] Kidney Problems [ ] Hepatitis [ ] HIV [ ] Depression [ ] Sinus Problems

Have you required any past medical care / evaluation for the following conditions? [ ] None
[ ] Chronic Cough [ ] Headaches [ ] Joint Pain [ ] Joint Swelling [ ] Dizziness [ ] General fatigue
[ ] Neck pain [ ] Muscle Spasms [ ] Sleep Problems [ ] Back pain [ ] Sciatica

Family History:
[ ] Cancer [ ] Diabetes [ ] High Blood Pressure [ ] Cardiovascular Problems/Stroke [ ] Other

Have you had prior chiropractic care? [ ] No [ ] Yes
Name of Treating Chiropractor: City/State:
What were you being treated for?

Have you had prior physical therapy?
Name of Physical Therapist: City/State:
What were you being treated for?

Have you had recent spinal x-rays? [ ] No [ ] Yes

Have you had a MRI or CT scan performed in the past? [ ] No [ ] Yes
Dates Taken What areas were taken?

Please list the medications you are currently taking:
Name of medication: List Condition:

I certify that the above information is complete and accurate.

Patient / Guardian Signature Date