Motor Vehicle Accident - New Patient

Today's Date:_______________ Patient Name: ____

Auto Insurance Company of Car You Were In:

____

Phone: ____

Insurance Agent:____ Phone _____________________________

Was A Police Report Made?___________ Have You Informed Your Agent of Your Injuries? __________________

Bodily Injury Claim Number (not collision claim #): ____

The Accident:

Date of Accident: _____________________ You Were: ___Driver ___ Passenger Front ___ Passenger Back

Briefly Describe The Accident:

____

____

Who Else Was In The Car With You At The Time Of The Accident?

____

Were Any of These People Injured? _________________ Where Did Your Vehicle Get Hit?____________________

Was Your Head or Body Turned or Rotated At The Time Of Impact? ______________

If Yes, What Direction Was Your Head or Body Turned or Rotated?____

Were You Wearing A Lap Belt? _________ Shoulder Belt? __________

Did You Feel Immediate Pain? ______ If Yes, Where____

Were You Rendered Unconscious?_______ For How Long: ____

Were You Cut Or Bleeding or Did You Get Bruised From Hitting Something Inside The Car?__________________

If Yes, Explain?____

Did You Strike Anything Inside Your Vehicle? Yes_____ No_____ Cannot Remember _____

Please Check All That Apply:

_____ Steering Wheel _____ Review Mirror _____ Dash _____ Side Pillars
_____ Windshield _____ Side Windows _____ Headrest _____ Roof

Other:__________________________ What Part Of Your Body Was Struck?_________________________________

Are You Presently Able To Work? ___________ If Yes, Are You Working In Pain?___________

Have You Lost Time From Work? Explain:____

After The Accident

Where Did You Go After The Accident? Home______ Work______ Hospital _______
Other_____________________

If You Went To The Hospital, How Were You Transported There?
____

Hospital Name____

If Admitted, How Long Did You Stay?______________________

What Care Did You Receive At The Hospital?

___ Exam ___ Stitches ___X-Rays ___Physical Therapy ___Neck Collar
___ Casting ___ Medication ___ MRI/CT Scan

Other____

What Treatment Have You Received To Date?

(1) Dr. _________________________ Specialty_______________________ Date Seen_______________________

Still Treating? _______ Special Testing: ____ MRI ___CAT SCAN ___X-Rays

Did This Doctor Refer You Elsewhere? _______ Did Treatment Received Help?_______

2) Dr. _________________________ Specialty_______________________ Date Seen_______________________

Still Treating? _______ Special Testing: ____ MRI ___CAT SCAN ___X-Rays

Did This Doctor Refer You Elsewhere? _______ Did Treatment Received Help?_______

Had You Enjoyed Good Health Prior To This Accident? ______ If No, Explain: ____________________________

____

As Related To The Accident, What Are Your Present Complaints? Please Check All That Apply:

___ Chest Pain ___ Headache ___ Spasming/Tension ___ Fatigue/Tiredness
___ Sleep Disruption ___ Upset Stomach ___ Low Back Pain ___ Neck Pain
___ Mid Back Pain ___ Ears Ringing ___ Depression
___ Change Of Sight/Memory/Breathing ___ Change Of Taste/Hearing/Smell
___ Leg/Foot/Toes Pain/Tingling/Numbness ___ Arm/ Hand/Fingers Pain/Tingling/Numbness

Other Complaints: ____

If You Have An Attorney Representing You, Name & Phone Number:

____

I Attest That The Information Provided Is Complete and True To The Best Of My Knowledge and Recollection:

Signed____ Date____________________________

LIFESTYLE CHIROPRACTIC
148 W. TIVERTON WAY, SUITE 140
LEXINGTON, KY 40503
PHONE: 859-271-5433
FAX: 859-271-0050

PATIENT INFORMATION FORM

DATE: ___/____/____ PATIENT NAME: ____________________________________

DATE OF BIRTH: ___/___/___ AGE: ______ SEX: M F

HOME ADDRESS: __________________________________ CITY/STATE:________ ZIP: ________________

HOME PH. #:(____) ____-_______WORK PH. #: (____) ____-_______CELL PH. #:(____) ____-_______

EMAIL: ____

EMERGENCY CONTACT PERSON: ________________________ RELATIONSHIP: ________________________

CONTACT PHONE #: (____) ____-_______

PRIMARY CARE DOCTOR: _____________________________ PHONE #: _______________________________

DATE OF MOST RECENT VISIT TO YOUR PRIMARY CARE DOCTOR? ______________________________________

REASON FOR THIS VISIT TO YOUR PRIMARY CARE DOCTOR :____

LIST BELOW THE PERSON(S) YOU GIVE US PERMISSION TO SHARE YOUR CLINICAL INFORMATION WITH ?

NAME: ____NAME: __________________________________

NAME:____ NAME: __________________________________

HOW DID YOU HEAR OF OUR OFFICE OR WHO REFERRED YOU TO US? __________________________________

PATIENT NAME: ______________________________

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION	DATE	REASON FOR HOSPITALIZATION	DATE

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED
☐ WIDOWED SPOUSES NAME: ______________________________

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENTLY USE: ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? ________ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? ________ TYPE______________

☐ CURRENTLY USE - TYPE ______________ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: ______________________ OCCUPATION: ______________________

DESCRIBE YOUR WORK DUTIES: ______________________________

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY
TYPE(S) OF EXERCISE:
____

FAMILY HISTORY

IS THERE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE
☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS
☐ OTHER ______________________________

YOUR MEDICAL HISTORY

WHAT ONGOING MEDICAL PROBLEMS/CONDITIONS ARE YOU BEING TREATED FOR?
____

HAVE YOU RECEIVED CHIROPRACTIC CARE IN THE PAST? IF SO, WHEN AND WHAT FOR?

____

Patient Name: ____

Give Dates of any Previous Car Accidents:____

Did You Receive Treatment For Any Of These Previous Accidents, And If So, What Treatment

Did You Get and From What Facility?____

Did Your Injuries/Symptoms From The Previous Car Accident(s) Resolve? _________________

Have You Been Treated For Neck Or Back Problems or Spinal Injuries, or any Spinal Condition(s) Before? _________

If Yes Please Give Details:____

Have You Had Any Previous Injuries (Falls, Broken Bones, Bad Sprains, etc.) ______________

If Yes Please Give Details:____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

CIRCLE THE CORRECT LETTER

Y = HAD IT BEFORE
N = NEVER HAD IT
P = HAVE IT NOW

ACID REFLUX	Y	N	P	FIBROMYALGIA	Y	N	P	NEUROPATHY	Y	N	P
ANEMIA	Y	N	P	GOUT	Y	N	P	OPEN SORES	Y	N	P
ARTHRITIS	Y	N	P	HEART ATTACK	Y	N	P	PNEUMONIA	Y	N	P
ASTHMA	Y	N	P	HEART DISEASE/FAILURE	Y	N	P	POLIO	Y	N	P
BACK TROUBLE	Y	N	P	HEPATITIS	Y	N	P	RHEUMATIC FEVER	Y	N	P
BLADDER INFECTIONS	Y	N	P	HIV+/AIDS	Y	N	P	SICKLE CELL DISEASE	Y	N	P
ABNORMAL BLEEDING	Y	N	P	HIGH BLOOD PRESSURE	Y	N	P	SKIN DISORDER	Y	N	P
BLOOD CLOTS	Y	N	P	KIDNEY DISEASE	Y	N	P	SLEEP APNEA	Y	N	P
BLOOD TRANSFUSION	Y	N	P	LIVER DISEASE	Y	N	P	STOMACH ULCERS	Y	N	P
BRONCHITIS/EMPHYSEMA	Y	N	P	LOW BLOOD PRESSURE	Y	N	P	STROKE	Y	N	P
CANCER	Y	N	P	MIGRAINE HEADACHES	Y	N	P	THYROID DISEASE	Y	N	P
DIABETES	Y	N	P	MITRAL VALVE PROLAPSE	Y	N	P	TUBERCULOSIS	Y	N	P
OTHER CONDITIONS:											

PATIENT NAME: ____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES TO MY MEDICAL STATUS.

PRINT NAME OF PATIENT, PARENT OR GUARDIAN ____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN ____

DATE: ____________________