

LifeLong Health & Wellness Center
Chiropractic Associates, PC
5540 South St. Ste. 200 Lincoln, NE 68506 402-488-1500

AUTOMOBILE / PERSONAL INJURY PATIENT INFORMATION

Patient Last Name: _____ M.I.: _____ First Name: _____
Patient Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell #: _____ Social Security _____
E-Mail Address: _____ Drivers License #: _____
Birth Date: _____ Age: _____ Marital Status S ___ M ___ D ___ W ___ Sep ___
Employer: _____ FT ___ PT ___ Employer Phone: _____

POLICY HOLDER INFORMATION

Relationship to Patient: Parent ___ Child ___ Spouse ___ Birth Date: _____
Last Name: _____ First Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell #: _____ E-Mail: _____
Employer: _____ Employer Phone: _____
Social Security Number: _____
Emergency Contact Not Living With You
Name: _____ Relationship: _____ Phone #: _____
Address: _____ Cell #: _____

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

Have you or are you considering applying for Medicaid? Y ___ N ___

AUTHORIZATION TO RELEASE INFORMATION: I hereby confirm that all the information provided by me is accurate. Any false information will result in my responsibility for any costs incurred due to fraudulent information. I authorize release of any medical or other information necessary to process my insurance claim.

Signature _____ Date _____

AUTHORIZATION OF PAYMENT: I realize that any insurance that I have is a contract between myself and that company. I authorize all insurance benefits to the Physician for services performed. I am responsible for providing the insurance information for the submission of claims. I am also responsible for any non-covered services or for services for which no referral was obtained.

Signature _____ Date _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES: I have had the opportunity to obtain a copy of Chiropractic Associates, P.C./LifeLong Health and Wellness (medical practice) Notice of Privacy Practices for Protected Health Information. I have been informed that I may have a copy of this notice at anytime. I have been informed that the Medical Practice has available to me a copy of the Notice of Privacy Practices for Protected Health Information posted in the waiting room for my use.

Signature _____ Date _____

LifeLong Health & Wellness Center
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MEDICAL SERVICES LIEN

RE: _____

I hereby authorize and direct you to pay directly to LifeLong Health & Wellness Center/Chiropractic Associates, PC such sums as may be due and owing for medical services rendered me both by reason of this accident and by reason of any other bills and finance charges that are due their office and to withhold such sums from my settlement, judgment, or verdict which may be paid to you, **LifeLong Health & Wellness Center/Chiropractic Associates, PC** or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by that attorney.

I fully understand that I am directly and fully responsible to LifeLong Health & Wellness Center/Chiropractic Associates, PC for all medical bills submitted by them for services rendered and for all accumulated finance charges, and that this agreement is made solely for LifeLong Health & Wellness Center/Chiropractic Associates, PC's additional protection and in consideration of their awaiting payment. And, I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the business office of LifeLong Health & Wellness Center/Chiropractic Associates, PC. I have been advised that if you do not wish to cooperate in protecting LifeLong Health & Wellness Center/Chiropractic Associates, PC's interest, LifeLong Health & Wellness Center/Chiropractic Associates, PC will not have to await payment, but may require me to make payments on a current basis.

Date

Patient's Signature

Date

Witness

The undersigned representative of record for the above patient does hereby agree to observe all of the terms of the above and agrees to withhold such sums from settlement, judgment, or verdict as may be necessary to adequately protect LifeLong Health & Wellness Center/Chiropractic Associates, PC.

Date

Attorney / Adjuster's Signature

LifeLong Health & Wellness Center
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FINANCIAL POLICY

Automobile Injury / Personal Injury PI

Once you have completed the required paperwork and supplied us with the appropriate insurance claim information we will accept assignment and bill the insurance at no charge for you. We will need the following:

- Your car insurance information. The company, agent, address, and the claim number.
- The party at fault's insurance information. The company, agent, address, and the claim number.
- Your health insurance information. A copy of your card will suffice.
- A signed lien to guarantee payment to LifeLong Health & Wellness Center/Chiropractic Associates, PC at settlement.

If someone hit you and is at fault their insurance company is responsible for your medical bills. As a rule, these companies do not make payment until you have been released from all care. This can take weeks, months, or in some cases, years.

Having your auto insurance info allows us to bill your med pay portion of you coverage and be paid as treatment continues. At the point you are released from care your insurance company will be repaid by the at fault company in full. **THIS WILL NOT AFFECT YOUR INSURANCE RATES.**

Once you are released from care or discontinue care on your own your balance becomes due. Interest will begin to accrue on your account after 60 days.

Any supplies (braces, pillows, vitamins...etc) must be paid for at the time taken. We will bill the appropriate insurer, however because historically these items are not covered we ask that they be paid for up front.

In the event a credit appears on your account due to overpayment by yourself or the insurer LifeLong Health & Wellness Center/Chiropractic Associates, PC will reimburse the appropriate party in a timely fashion.

I _____ understand the financial policy as read to me and agree to abide by it. I also understand that in the event my claim is denied or not paid in full at settlement I am personally responsible for the remaining balance.

Signed _____ Date _____

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Automobile Accident History	
Please Print	
Name: _____	Date: _____
Date of Accident: _____	Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
Driver of car: _____	Where were you seated? _____
Car's Owner: _____	Year and Model of car: _____
What was the approximate damage done to the car? \$ _____	
Where did the accident occur? _____	
Visibility at the time of accident: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good	
Road conditions at the time of the accident: <input type="checkbox"/> Icy <input type="checkbox"/> Rainy <input type="checkbox"/> Wet <input type="checkbox"/> Clear <input type="checkbox"/> Dark	
Your car: <input type="checkbox"/> Hit another car <input type="checkbox"/> Was hit in the: <input type="checkbox"/> Right side <input type="checkbox"/> Left side <input type="checkbox"/> Rear <input type="checkbox"/> Front	
Type of Accident: <input type="checkbox"/> Head-on collision <input type="checkbox"/> Broad-side collision <input type="checkbox"/> Rear-end collision	
<input type="checkbox"/> Front-impact, Rear-ended car in front <input type="checkbox"/> Single vehicle collision <input type="checkbox"/> Other (explain): _____	

Impact/ Seat Belt/ Headrest/ Speed/ Body Position	
Describe in your words what happened to you upon impact: _____	

<input type="checkbox"/> Yes <input type="checkbox"/> No Did you see the accident coming?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Were you pre-warned that the accident was about to happen?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Did you brace for impact?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Did you have your hands on the steering wheel at impact?	
Head/Body position at the time of impact: <input type="checkbox"/> Head Turned <input type="checkbox"/> Right <input type="checkbox"/> Left	
<input type="checkbox"/> Head straight forward <input type="checkbox"/> Body straight in sitting position <input type="checkbox"/> Looking back	
At the time of the accident, what parts of your head/body hit what parts of the inside of the car?:	

<input type="checkbox"/> Yes <input type="checkbox"/> No Were you wearing glasses, a hat, or dentures? Where were they after the accident?	

<input type="checkbox"/> Yes <input type="checkbox"/> No Were seat belts worn?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Were shoulder harnesses worn?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Does your car have headrests? If yes, what was their position compared to your head before the accident?	
<input type="checkbox"/> Top of headrest even with middle of neck <input type="checkbox"/> Top of headrest even with bottom of head	
<input type="checkbox"/> Top of headrest even with top of head	
<input type="checkbox"/> Yes <input type="checkbox"/> No Was your car braking?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Was your car moving at the time of the accident?	
If so, how fast do you estimate you were going? _____ MPH	
How fast do you estimate the other vehicle was moving? _____ MPH	
How many people were in your vehicle? _____	

Ability To Move Body	
<input type="checkbox"/> Yes <input type="checkbox"/> No Were you in the car prior to the accident?	
<input type="checkbox"/> Yes <input type="checkbox"/> No After the accident?	
As a result of the accident, were you: <input type="checkbox"/> Rendered unconscious <input type="checkbox"/> Dazed, situation vague	
<input type="checkbox"/> Shaken up but could function	
<input type="checkbox"/> Yes <input type="checkbox"/> No Could you move all parts of your body? If no, what parts and why not? _____	

<input type="checkbox"/> Yes <input type="checkbox"/> No Were you able to get out of the car unaided? If no, why not? _____	

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Symptoms From Accident

Yes No Did you receive bleeding cuts or bruises? If cuts, where? _____
If bruises where? _____

Please describe how you felt. PLEASE BE SPECIFIC :
Immediately after the accident: _____
Later that: Day Night: _____
The next day(s): _____

Check symptoms that have become apparent since the accident:

1. <input type="checkbox"/> Nervousness	10. <input type="checkbox"/> Ringing/buzzing ears	19. <input type="checkbox"/> Irritability	28. <input type="checkbox"/> Diarrhea
2. <input type="checkbox"/> Neck pain/stiffness	11. <input type="checkbox"/> Loss of balance	20. <input type="checkbox"/> Depression	29. <input type="checkbox"/> Fatigue
3. <input type="checkbox"/> Mid back pain	12. <input type="checkbox"/> Loss of smell	21. <input type="checkbox"/> Sleeping trouble	30. <input type="checkbox"/> Tension
4. <input type="checkbox"/> Low back pain	13. <input type="checkbox"/> Loss of taste	21. <input type="checkbox"/> Toe numbness	31. <input type="checkbox"/> Fever
5. <input type="checkbox"/> Eyes sensitive to light	14. <input type="checkbox"/> Loss of memory	22. <input type="checkbox"/> Finger Numbness	32. <input type="checkbox"/> Headache
6. <input type="checkbox"/> Pain behind eyes	15. <input type="checkbox"/> Pins & Needles - Arms	24. <input type="checkbox"/> Cold hands	34. <input type="checkbox"/> Anxiety
7. <input type="checkbox"/> Dizziness	16. <input type="checkbox"/> Pins & Needles - Legs	25. <input type="checkbox"/> Cold feet	35. <input type="checkbox"/> Seizures
8. <input type="checkbox"/> Cold sweats	17. <input type="checkbox"/> Shortness of breath	26. <input type="checkbox"/> Chest pain	36. <input type="checkbox"/> Visual disturbances
9. <input type="checkbox"/> Face Flushed	18. <input type="checkbox"/> Head seems too heavy	27. <input type="checkbox"/> Constipation	37. <input type="checkbox"/> Other _____

Work Status History

Occupation: _____ Employer: _____

Yes No Have you missed time from work? If no, who told you to return to work? _____
If yes, Off work full-time Dates: _____
 Off work part-time Dates: _____
 Unable to return to work since accident.

What type of physical activity is required at work? _____

First Doctor/ Hospital/ Clinic

Yes No Did you seek medical help immediately after the accident? If yes, how did you get there?
 Someone else drove me Drove own car Police Ambulance

Doctor/Hospital/Clinic: _____ Date of first visit: _____

Yes No Were you examined?
 Yes No Were X-rays taken?
What diagnosis did the doctor give you? _____

Yes No Were you given treatment? If yes, what type? _____
What benefits did you receive from this treatment? _____
Date of last treatment: _____

Yes No Did the Doctor refer you to another health professional? If so to who and for what? _____

Did you follow the doctor's recommendation? If no, why not?: _____

Second Doctor/ Hospital/ Clinic

Doctor/Hospital/Clinic: _____ Date of first visit: _____

Yes No Were you examined?
 Yes No Were X-rays taken:
 Yes No Were you given treatment? If yes, what type? _____
What benefits did you receive from this treatment? _____
Date of last treatment: _____

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Prior Similar Symptoms

- Yes No Did you have any physical complications must before the accident? If yes, please describe in detail: _____
- Yes No Prior to this accident, have you ever had similar symptoms? If yes, please describe in detail: _____
- Yes No Have you ever been in accidents prior to this one? If yes, when? _____
Where? _____
How was it treated? _____ Results of treatment: _____
- Yes No Are you now being treated?
- Yes No Do you have any congenital (birth) factors which relate to this problem? If yes please describe: _____

Attorney Involved In Case

- Yes No Do you have an attorney involved in this case?
If yes, Name: _____
Address: _____
Phone: _____

Insurance Information

Your Vehicle:

Insurance Co. _____
Address _____

Phone _____
Claim Number _____
Adjuster _____
Address _____

Phone _____

Other Vehicle:

Driver _____
Insurance Co. _____
Address _____

Phone _____
Claim Number _____
Adjuster _____
Address _____

Phone _____

Vehicle at Fault: **Yours** _____ **Other** _____

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Confidential Patient Health Record

Patient Name : _____

Today's Date: ____/____/____

How did you hear about us? Family _____ Friend _____ Co-Worker _____
 Close to home/work Dr. _____ Yellow pages Drove by Hospital Insurance Plan

Personal Information

CURRENT HEALTH CONDITION

Chief complaint (Why you are here today): _____

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

When did this condition begin? ____/____/____

Has it ever occurred before? Yes No

When? _____

Is the condition: Auto Related Work Related
 No Injury Other

Explain: _____

Date of Accident: _____

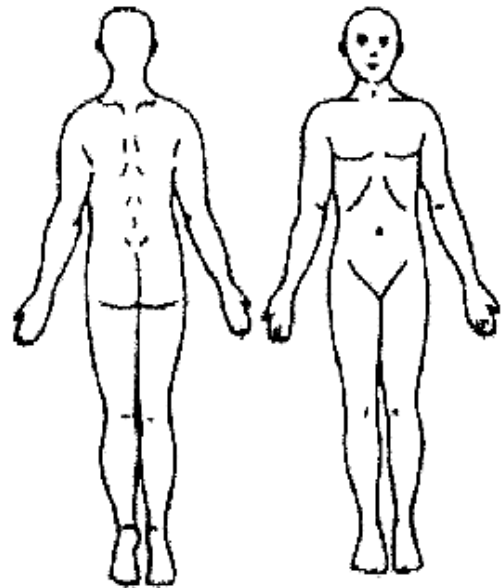
Time of Accident: _____

Complaint/Pain Onset Date: _____

If Work Related:

Have you filed an injury report with your employer? Yes No

Claim #: _____



Use the letters below to indicate the type and location of your sensations right now:
 A=Ache B=Burning N=Numbness P=Pins & Needles S=Stabbing O=Other

REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care. Have you had the following symptoms or problems either in the past or now? Please check the appropriate boxes.

General: I DENY having or have had any of the symptoms or problems listed below.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> chills | <input type="checkbox"/> fatigue | <input type="checkbox"/> night sweats | <input type="checkbox"/> weight loss |
| <input type="checkbox"/> fever | <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> weight gain |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> rashes | <input type="checkbox"/> unusual lymph glands or lumps |
| <input type="checkbox"/> daytime drowsiness | <input type="checkbox"/> sleep difficulties | <input type="checkbox"/> risk factors for AIDS | |

Eyes/Vision: I DENY having any of the symptoms or problems listed below.

- | | | | |
|---|---|-------------------------------------|--|
| <input type="checkbox"/> blindness | <input type="checkbox"/> change in vision | <input type="checkbox"/> field cuts | <input type="checkbox"/> photophobia |
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> double vision | <input type="checkbox"/> glaucoma | <input type="checkbox"/> tearing |
| <input type="checkbox"/> cataracts | <input type="checkbox"/> eye pain | <input type="checkbox"/> itching | <input type="checkbox"/> wear glasses/contacts |

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Name: _____

Date: _____

Ears, Nose and Throat: I DENY having any of the symptoms or problems listed below.

- | | | | | |
|--|---|---|---|---|
| <input type="checkbox"/> bleeding | <input type="checkbox"/> ear drainage | <input type="checkbox"/> hearing loss | <input type="checkbox"/> nosebleeds | <input type="checkbox"/> sore throat |
| <input type="checkbox"/> dentures | <input type="checkbox"/> ear pain | <input type="checkbox"/> history of head injury | <input type="checkbox"/> postnasal drip | <input type="checkbox"/> nasal congestion |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> fainting | <input type="checkbox"/> hoarseness | <input type="checkbox"/> snoring | <input type="checkbox"/> TMJ problems |
| <input type="checkbox"/> discharge | <input type="checkbox"/> frequent sore throats | <input type="checkbox"/> loss of sense of smell | <input type="checkbox"/> sinus infections | <input type="checkbox"/> headaches |
| <input type="checkbox"/> tinnitus
(ringing in ears) | <input type="checkbox"/> difficulty
swallowing | <input type="checkbox"/> rhinorrhea
(runny nose) | <input type="checkbox"/> bleeding gums | <input type="checkbox"/> migraines |

Respiration: I DENY having any of the symptoms or problems listed below.

- | | | | |
|---------------------------------|--|--|--|
| <input type="checkbox"/> asthma | <input type="checkbox"/> coughing up blood | <input type="checkbox"/> sputum production | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> cough | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> wheezing | <input type="checkbox"/> recurrent pneumonia or bronchitis |

Cardiovascular: I DENY having any of the symptoms or problems listed below.

- | | | |
|---|---|---|
| <input type="checkbox"/> angina (chest pain or discomfort) | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> low blood pressure | <input type="checkbox"/> bruise or bleed easily |
| <input type="checkbox"/> claudication (leg-calf pain/ache) | <input type="checkbox"/> swelling of legs | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> heart murmur | <input type="checkbox"/> palpitations | <input type="checkbox"/> heart failure |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> racing heart | <input type="checkbox"/> blood transfusion |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> orthopnea (difficulty breathing lying down) | <input type="checkbox"/> blood clotting |
| <input type="checkbox"/> shortness of breath
with exertion or exercise | <input type="checkbox"/> paroxysmal nocturnal dyspnea
(waking at night w/ shortness of breath) | |

Gastrointestinal: I DENY having any of the symptoms or problems listed below.

- | | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> abdominal pain | <input type="checkbox"/> diarrhea | <input type="checkbox"/> indigestion | <input type="checkbox"/> abnormal stool | <input type="checkbox"/> vomiting blood |
| <input type="checkbox"/> belching | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> jaundice | <input type="checkbox"/> abnormal stool color | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> black - tarry stools | <input type="checkbox"/> heartburn | <input type="checkbox"/> nausea | <input type="checkbox"/> abnormal stool consistency | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> constipation | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> rectal bleeding | <input type="checkbox"/> vomiting | |

Female: I DENY having any of the symptoms/problems and/or using any of the items listed below.

- | | | | |
|--|---|---|------------------------------------|
| <input type="checkbox"/> hormone therapy | <input type="checkbox"/> vaginal bleeding | <input type="checkbox"/> burning urination | <input type="checkbox"/> pregnancy |
| <input type="checkbox"/> breast lumps/pain | <input type="checkbox"/> vaginal discharge | <input type="checkbox"/> urine retention | # of pregnancies: _____ |
| <input type="checkbox"/> discharge from nipple | <input type="checkbox"/> irregular menstruation | <input type="checkbox"/> frequent urination | # of living children: _____ |
| <input type="checkbox"/> cramps | <input type="checkbox"/> Abnormal Pap test | <input type="checkbox"/> birth control | Age of onset of Period: _____ |
| | Last Pap date: _____ | method: _____ | Cycle; _____ days (start to start) |

Male: I DENY having any of the symptoms or problems listed below.

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> burning urination | <input type="checkbox"/> frequent urination | <input type="checkbox"/> prostate problems | <input type="checkbox"/> discharge from penis |
| <input type="checkbox"/> erectile dysfunction | <input type="checkbox"/> hesitancy/dribbling | <input type="checkbox"/> urine retention | <input type="checkbox"/> lump in testicles |

Endocrine: I DENY having any of the symptoms or problems listed below.

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> cold intolerance | <input type="checkbox"/> excessive hunger | <input type="checkbox"/> goiter | <input type="checkbox"/> unusual hair growth |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> excessive thirst | <input type="checkbox"/> hair loss | <input type="checkbox"/> voice changes |
| <input type="checkbox"/> excessive appetite | <input type="checkbox"/> abnormal frequency of urination | <input type="checkbox"/> heat intolerance | |

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Date: _____

Urinary: I DENY having any of the symptoms or problems listed below.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> kidney stones | <input type="checkbox"/> burning with urination | <input type="checkbox"/> blood in urine | <input type="checkbox"/> sexual problems |
| <input type="checkbox"/> kidney disease | <input type="checkbox"/> slow urine flow | <input type="checkbox"/> venereal disease | |
| <input type="checkbox"/> bladder or kidney infection | | <input type="checkbox"/> difficulty starting or controlling urination | |

Skin: I DENY having any of the symptoms or problems listed below.

- | | | | |
|--|--------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> changes in nail texture | <input type="checkbox"/> hair loss | <input type="checkbox"/> itching | <input type="checkbox"/> skin lesions / ulcers |
| <input type="checkbox"/> changes in skin color | <input type="checkbox"/> hives | <input type="checkbox"/> paresthesias | <input type="checkbox"/> varicosities |
| <input type="checkbox"/> history of skin disorders | <input type="checkbox"/> hair growth | <input type="checkbox"/> rash | |

Bones/Joints/Muscles: I DENY having any of the symptoms or problems listed below.

- painful or swollen joints persistent back or neck pain muscle cramps osteoporosis

Nervous System: I DENY having any of the symptoms or problems listed below.

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> dizziness | <input type="checkbox"/> loss of consciousness | <input type="checkbox"/> loss of memory | <input type="checkbox"/> slurred speech | <input type="checkbox"/> tremors |
| <input type="checkbox"/> facial weakness | <input type="checkbox"/> facial numbness | <input type="checkbox"/> seizures/epilepsy | <input type="checkbox"/> stress | <input type="checkbox"/> unsteadiness of gait/
loss of balance |
| <input type="checkbox"/> limb weakness | <input type="checkbox"/> limb numbness | <input type="checkbox"/> sleep disturbance | <input type="checkbox"/> strokes | |
| <input type="checkbox"/> headache | | | | |

Psychologic: I DENY having any of the symptoms or problems listed below.

- | | | | |
|---|--|--------------------------------------|--|
| <input type="checkbox"/> crying spells | <input type="checkbox"/> behavioral change | <input type="checkbox"/> convulsions | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> memory problems | <input type="checkbox"/> bi-polar disorder | <input type="checkbox"/> depression | <input type="checkbox"/> mood change |
| <input type="checkbox"/> loss or change in appetite | <input type="checkbox"/> suicidal thoughts | <input type="checkbox"/> insomnia | <input type="checkbox"/> job or family
difficulty |
| <input type="checkbox"/> loss of interest in previously
enjoyable things | <input type="checkbox"/> suicide attempts | <input type="checkbox"/> confusion | |

Allergy: I DENY having any of the symptoms or problems listed below.

- | | | | |
|---|---|---|-----------------------------------|
| <input type="checkbox"/> anaphalaxis | <input type="checkbox"/> itching | <input type="checkbox"/> chronic nasal congestion | <input type="checkbox"/> sneezing |
| <input type="checkbox"/> food intolerance | <input type="checkbox"/> acute nasal congestion | <input type="checkbox"/> rash | |

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Care for this Same Condition:

I have not previously seen a doctor for this condition OR Fill in the information BELOW

Have you seen other doctors for THIS CONDITION? Yes No. If yes, Who? (Name) _____

Type of Treatment: _____ Were you satisfied with the results of your treatment? Yes No

Explain: _____

Previous Chiropractic Care: I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name: _____ Location: _____ Date of Last Visit: _____

Were you satisfied with your care? Yes No. Why? _____

Do you wear any of the following? Heel Lifts Innersoles Arch Supports Orthotics Other _____

For how long? _____ Were they prescribed by a doctor? Yes or No.

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Name: _____

Date: _____

Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage / Times Daily	For What Condition?	How long have you been taking this?

Medication Allergies: List ANY/ALL medications you are allergic to and the type of reaction. Be Specific.

Medications	Reaction

Current Vitamins, Herbs, etc: List ANY/ALL non-prescription items you are CURRENTLY taking. Be Specific.

	Dosage	For What Condition, if any?	How long have you been taking this?

Surgery (ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> angioplasty | <input type="checkbox"/> cosmetic | <input type="checkbox"/> hysterectomy | <input type="checkbox"/> pacemaker insertion |
| <input type="checkbox"/> appendectomy | <input type="checkbox"/> D & C | <input type="checkbox"/> joint reconstruction | <input type="checkbox"/> rotator cuff |
| <input type="checkbox"/> caesarian section | <input type="checkbox"/> dental sugery | <input type="checkbox"/> joint replacement | <input type="checkbox"/> spinal fusion |
| <input type="checkbox"/> cardiac catheterization | <input type="checkbox"/> gall bladder | <input type="checkbox"/> knee repair | <input type="checkbox"/> tonsilectomy |
| <input type="checkbox"/> carpal tunnel repair | <input type="checkbox"/> hemorrhoidectomy | <input type="checkbox"/> laminectomy | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> coronary artery bypass | <input type="checkbox"/> hernia repair | <input type="checkbox"/> mastectomy | _____ |

Childhood Illness (es): LIST all health conditions. CIRCLE all CURRENT conditions.

- | | | | |
|---|--|------------------------------------|---|
| <input type="checkbox"/> ADD | <input type="checkbox"/> chicken pox | <input type="checkbox"/> headaches | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> atopic dermatitis (eczema) | <input type="checkbox"/> Crohn's/colitis | <input type="checkbox"/> hepatitis | <input type="checkbox"/> seizure disorder |
| <input type="checkbox"/> allergies/hayfever | <input type="checkbox"/> depression | <input type="checkbox"/> HIV | <input type="checkbox"/> sickle cell anemia |
| <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes | <input type="checkbox"/> measles | <input type="checkbox"/> spina bifida |
| <input type="checkbox"/> asthma | <input type="checkbox"/> ear infections | <input type="checkbox"/> mumps | <input type="checkbox"/> other: |
| <input type="checkbox"/> bedwetting | <input type="checkbox"/> fetal drug exposure | <input type="checkbox"/> psoriasis | |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> food allergies (list below) | <input type="checkbox"/> rash | |

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Do you believe that the Adult Illnesses listed below are contributory to your CURRENT Condition? yes or no.

Adult Illness (es): LIST all health conditions. CIRCLE all CURRENT conditions.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> ADD | <input type="checkbox"/> cystic kidney disease | <input type="checkbox"/> hypertension | <input type="checkbox"/> psychiatric problems |
| <input type="checkbox"/> alzheimers | <input type="checkbox"/> depression | <input type="checkbox"/> influenzal pneumonia | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes (insulin dep) | <input type="checkbox"/> liver disease | <input type="checkbox"/> seizures |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> diabetes (non insulin) | <input type="checkbox"/> lung disease | <input type="checkbox"/> shingles |
| <input type="checkbox"/> asthma | <input type="checkbox"/> eczema | <input type="checkbox"/> lupus erythema (discoïd) | <input type="checkbox"/> past history of similar symptoms |
| <input type="checkbox"/> cancer | <input type="checkbox"/> emphysema | <input type="checkbox"/> lupus erythema (systemic) | <input type="checkbox"/> STD's (unspecified) |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> eye problems | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> suicide attempt(s) |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> parkinson's disease | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> Crohn's/colitis | <input type="checkbox"/> heart disease | <input type="checkbox"/> unspecified pleural effusion | <input type="checkbox"/> vertigo |
| <input type="checkbox"/> CRPS (RSD) | <input type="checkbox"/> hepatitis | <input type="checkbox"/> pneumonia | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> HIV | <input type="checkbox"/> psoriasis | _____ |

Females ONLY: Ob/Gyn Mark all that apply below.

If you have been pregnant in the past, please fill in the appropriate information below.

_____ Number of complicated pregnancies	_____ Number of uncomplicated pregnancies
_____ Number of C-sections	_____ Number of vaginal deliveries
_____ Number of miscarriages	_____ Number of terminated pregnancies
I... <input type="checkbox"/> am currently pregnant	<input type="checkbox"/> am NOT currently pregnant

Injury (ies): Mark or List All Injuries. Write the DATE of the Injury immediately afterward.

- | | | |
|---|---|--|
| <input type="checkbox"/> back injury | <input type="checkbox"/> head injury (loss of consciousness) | <input type="checkbox"/> motor vehicle accident |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> head injury (no loss of consciousness) | <input type="checkbox"/> soft tissue injury (mild) |
| <input type="checkbox"/> disability (ies) | <input type="checkbox"/> industrial accident | <input type="checkbox"/> soft tissue injury (moderate) |
| <input type="checkbox"/> fall (severe) | <input type="checkbox"/> joint injury | <input type="checkbox"/> soft tissue injury (severe) |
| <input type="checkbox"/> fracture | <input type="checkbox"/> laceration (severe) | <input type="checkbox"/> other: _____ |

Immunizations: Please list the date(s) next to the immunization, if known.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> adenovirus | <input type="checkbox"/> hepatitis C | <input type="checkbox"/> pertussis | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> anthrax | <input type="checkbox"/> influenza | <input type="checkbox"/> pneumococcal | <input type="checkbox"/> tularemia |
| <input type="checkbox"/> botulism | <input type="checkbox"/> IPV (polio) | <input type="checkbox"/> pneumovax | <input type="checkbox"/> typhoid |
| <input type="checkbox"/> flu | <input type="checkbox"/> Japanese encephalitis | <input type="checkbox"/> PPD (mantoux test- TB) | <input type="checkbox"/> varivax (chicken pox) |
| <input type="checkbox"/> haemophilus B | <input type="checkbox"/> lyme disease | <input type="checkbox"/> rabies | <input type="checkbox"/> whooping cough (pertussis) |
| <input type="checkbox"/> hepatitis A | <input type="checkbox"/> measles | <input type="checkbox"/> rotavirus | <input type="checkbox"/> yellow fever |
| <input type="checkbox"/> hepatitis B | <input type="checkbox"/> meningococcal | <input type="checkbox"/> rubella | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> diphtheria | <input type="checkbox"/> MMR | <input type="checkbox"/> smallpox | _____ |
| <input type="checkbox"/> DTaP (diphtheria, tetanus, pertussis) | <input type="checkbox"/> mumps | <input type="checkbox"/> tetanus | _____ |

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Name: _____

Date: _____

Non-Drug Allergies: Mark all that apply below.

- | | | | |
|--|--|------------------------------------|------------------------------------|
| <input type="checkbox"/> adhesive tape | <input type="checkbox"/> eggs | <input type="checkbox"/> newsprint | <input type="checkbox"/> shellfish |
| <input type="checkbox"/> animals | <input type="checkbox"/> feathers | <input type="checkbox"/> nuts | <input type="checkbox"/> smoke |
| <input type="checkbox"/> bee sting | <input type="checkbox"/> food coloring | <input type="checkbox"/> peanuts | <input type="checkbox"/> soap |
| <input type="checkbox"/> chocolate | <input type="checkbox"/> latex | <input type="checkbox"/> perfumes | <input type="checkbox"/> soy |
| <input type="checkbox"/> dairy | <input type="checkbox"/> mold | <input type="checkbox"/> pollen | <input type="checkbox"/> wheat |
| <input type="checkbox"/> other: _____ | | | |

Social History: Mark all that apply below.

Tobacco:	<input type="checkbox"/> None	<input type="checkbox"/> Pipe/Cigar	<input type="checkbox"/> Chew	<input type="checkbox"/> Cigarettes: Amt/day _____	
				How long? _____	<input type="checkbox"/> Quit?
Alcohol:	<input type="checkbox"/> 1/wk-2/day	<input type="checkbox"/> Weekends	<input type="checkbox"/> None	<input type="checkbox"/> Over 2 daily	<input type="checkbox"/> Quit?
Coffee:	<input type="checkbox"/> 0-4 cups daily	<input type="checkbox"/> More: _____		Last Tetanus shot date: _____	
Meals?	<input type="checkbox"/> Reg low-fat	<input type="checkbox"/> Regular	<input type="checkbox"/> Often Skip	<input type="checkbox"/> Fast food	
Exercise:	<input type="checkbox"/> Regular	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Rarely	<input type="checkbox"/> No	
Use of Seat Belts	<input type="checkbox"/> Yes	<input type="checkbox"/> Occasionally	<input type="checkbox"/> No		
Use of Street Drugs	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details: _____		
Treatment of Alcohol abuse	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details: _____		
Treatment of Drug abuse	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details: _____		

Family History: Mark all that apply below.

Family History	Age	Deceased	Alcoholism	Arthritis	Bleeds easily	Cancer	Diabetes	Epilepsy	Heart Disease	Blood Pressure	High Cholesterol	Kidney Disease	Mental Illness	Migraine	Stroke	TB	Thyroid Disease	Other
Father																		
Mother																		
Bro/Sis																		
Bro/Sis																		
Spouse																		
child																		
child																		

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QUADRUPLE VISUAL ANALOGUE SCALE
(QUAD-VAS)

Patient Name: _____

Date: _____

Please read carefully:

Instructions: Please circle the number and list the area of your complaint that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

No pain Headache Neck Low Back worst possible
pain 0 1 2 3 4 5 6 7 8 9 10
 (1) (5) (8)

1 – What is your pain RIGHT NOW?

No pain _____ worst possible pain
 0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ worst possible pain
 0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?

No pain _____ worst possible pain
 0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?

No pain _____ worst possible pain
 0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

Examiner

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