GONSTEAD FAMILY CHIROPRACTIC
FAMILY CARE • INJURIES • PAIN RELIEF

NEW PATIENT INTAKE FORM -- Personal Injury

PATIENT INFORMATION

CONFIDENTIAL

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We will be happy to help.

Name____ Date_____/_____/_____ S/S______-______-______
First MI Last
Address____ City________________ State_____ Zip___________

Home Phone_______________________ Work Phone________________________ Cell Phone____________________

Birth Date_____/_____/_____ Height________ Weight________ E-mail address:______________________________

Sex: ❒ Female ❒ Male **Status:** ❒ Minor ❒ Married ❒ Single ❒ Other

Your Employer____ Occupation_________________________________

Business Address_____________________________________ City________________ State_____ Zip__________

Spouse/ Parent's Name____ Phone_______________

Who may we thank for referring you to us?____

Person to contact in case of an emergency____ Phone_______________

INSURANCE CO. ____________________________________ Policy # _____________________________________

Name on Policy (if not self) ____

Responsible Party's Name ______________________________ Agent's name ___________________________

Address ____

ATTORNEY _______________________________________ Phone ____________________________________

Address ____

HEALTH HISTORY

Please check the following symptoms you have noticed **SINCE THE ACCIDENT** (❍) or **BEFORE THE ACCIDENT** (❒):

❍ ❒ Headaches	❍ ❒ Irritability	❍ ❒ Loss of Smell
❍ ❒ Neck Pain	❍ ❒ Mood Swings	❍ ❒ Loss of Taste
❍ ❒ Neck Stiffness	❍ ❒ Sleeping Problems	❍ ❒ Upset Stomach
❍ ❒ Mid Back Pain	❍ ❒ Fatigue	❍ ❒ Constipation
❍ ❒ Low Back Pain	❍ ❒ Depression	❍ ❒ Diarrhea
❍ ❒ Arm Pain	❍ ❒ Chest Pain	❍ ❒ Urinary Problems
❍ ❒ Leg Pain	❍ ❒ Shortness of Breath	❍ ❒ Heartburn
❍ ❒ Pins and Needles in Arms	❍ ❒ Cold Sweats	❍ ❒ Ulcers
❍ ❒ Pins and Needles in Legs	❍ ❒ Fever	❍ ❒ Allergies
❍ ❒ Numbness in Fingers	❍ ❒ Fainting	❍ ❒ Menstrual Pain
❍ ❒ Numbness in Toes	❍ ❒ Dizziness	❍ ❒ Menstrual Irregularity
❍ ❒ Cold Hands	❍ ❒ Loss of Balance	❍ ❒ Hot flashes
❍ ❒ Cold Feet	❍ ❒ Light Sensitivity with Eyes	❍ ❒ Other _____________
❍ ❒ Nervousness	❍ ❒ Ringing/ Buzzing in Ears	❍ ❒ Other _____________
❍ ❒ Tension	❍ ❒ Loss of Memory	

Have **YOU** (❍) or **A FAMILY MEMBER** (❒) ever been diagnosed with any of the following conditions:

❍ ❒ AIDS/HIV	❍ ❒ Heart Disease	❍ ❒ None
❍ ❒ Cancer	❍ ❒ Diabetes	❍ ❒ Unknown
❍ ❒ High Blood Pressure	❍ ❒ Stroke	❍ ❒ Other ___________

NATURE OF ACCIDENT

Date of accident _____/_____/_____ Time of Day ___________ Location of accident ______________________________

Relative speed of you car ___________________ (mph) Relative speed of the other car _______________(mph)

What was the site of impact on your car?

❒ Behind ❒ Front

❒ Driver's Side ❒ Passenger's Side

Where were you sitting at the time of impact?

❒ Driver

❒ Passenger …. ❒ Front ❒ Back

Were you wearing your seat belt?... ❒ No ❒ Yes Did your airbags deploy? ❒ No ❒ Yes

Were your brakes applied?……..… ❒ No ❒ Yes Did your seat back break? ❒ No ❒ Yes

PLEASE DESCRIBE THE ACCIDENT in your own words: ____

____

____

List any parts of your body that struck the following vehicle parts during the accident:

Dashboard: ____ Door: ____________________________________

Windshield: ____ Door Window: ______________________________

Steering Wheel: ____ Other: ___________________________________

Your Vehicle Type ______________________________________ Other Vehicle Type ________________________

Did you lose consciousness? ❒ No ❒ Yes, for how long? ____

ADDITIONAL INFORMATION:

What was your mental and emotional state immediately following the accident? _________________________

Were the police notified? ❒ No ❒ Yes Did you receive medical attention at the scene of the accident? ❒ No ❒ Yes

Where did you go immediately following the accident? ____

Have you been treated by another doctor since the accident? ❒ No ❒ Yes , If yes…

Please list the name of the doctor and address: ____

Please explain what type of treatment you received: ____

What type of X-rays were taken if any? ____

Do you have any congenital (from birth) factors that may relate to this problem? ❒ No ❒ Yes,

____

Do you have any previous illnesses which relate to this case ❒ No ❒ Yes,

____

Have you ever been involved in an accident before? ❒No ❒Yes, _____________________________________

Have you lost time from work as a result of this accident? ❒ No ❒ Yes, If yes…

Last day worked: _____/_____/_____ Type of employment: ___________________________________

PLEASE DESCRIBE HOW YOU FELT:

DURING the accident: ____

IMMEDIATELY AFTER the accident: ____

LATER THAT DAY: ____

THE NEXT DAY: ____

Please add any other information that you feel is pertinent: ______________________________________

____

____

PLEASE LIST YOUR CURRENT AREAS OF COMPLAINT:

(chief complaint)

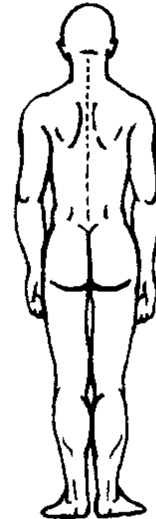
1) ___________________________ 2) ________________________ 3) ________________________ 4) ________________________

0 1 2 3 4 5 6 7 8 9 10   0 1 2 3 4 5 6 7 8 9 10   0 1 2 3 4 5 6 7 8 9 10   0 1 2 3 4 5 6 7 8 9 10

CIRCLE THE NUMBER THAT BEST DESCRIBES THE INTENSITY OF YOUR PAIN: 1 = Mild, 10 = Severe

PLEASE MARK YOUR AREAS OF COMPLAINT ON THE BODY DIAGRAM USING THE FOLLOWING KEY:

Dull	= D
Aching	= A
Stiffness	= S
Burning	= B
Tingling	= T
Numbness	= N
Sharp	= !!!
Shooting	= XXX
Other______________	= ***



How often do you notice your symptoms? ❒ Constantly ❒ Frequently ❒ Occasionally

Does anything relieve your pain?____

What activities are difficult to perform? ❒ Sitting ❒ Standing ❒ Walking ❒ Bending ❒ Lying Down

Please describe any other activities that are restricted due to this injury?_______________________________

____

Is the condition getting worse? ❒ No ❒ Yes

Have you had this problem before? ❒ No ❒ Yes, When?_________________________________

Have you ever been diagnosed with a Subluxation? ❒ No ❒ Yes, When? ___________________________

Have you had x-rays before? ❒ No ❒ Yes, When? ___________________ What areas? _____________________

I am currently taking the following medications for the following reasons: ❒ None

____

____

Surgical History: ____ ❒ None

For Women Only: Is there a possibility that you may be pregnant? ❒ No ❒ Yes

Which best describes your health goals: ❒ Pain relief only ❒ Correct entire problem ❒ Wellness/ preventative care

DATE: ____/____/____ **SIGNATURE:** _______________________________________

PARENT/GUARDIAN: _______________________________________