Chiropractic Wellness Group

969 E. Green Street, Pasadena CA 91106
(626) 584-WELL

CONFIDENTIAL PATIENT INFORMATION

Accident Report

The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of this form. If you need any help please ask the receptionist.

PATIENT DATA:

Social Security #: ____________

(First name, middle initial, last name) **Email:** ____________ **Cell Phone:** ____________

Name ____________ **Home Phone** ____________ **Driver License #** ____________

Home Address ____________ **City** ____________ **Zip Code** ____________

Mailing Address ____________ **City** ____________ **Zip Code** ____________

Emergency Contact (Name & Number) ____________

Age _____ **Date of Birth** ____________ **Marital: M S W D** **How Many Children?** ______

Occupation ____________ **Employer** ____________

Employer's Address ____________ **Office Phone** ____________

Name of Spouse or Parent (circle one) ____________ **Occupation** ____________

Spouse or Parents' Employer ____________ **Office Phone** ____________

Patient's Nearest Relative (other than Spouse) ____________ **Relationship** ____________

Relative's Address ____________ **City** ____________ **Zip Code** ____________

How were you referred to our office? ____________

Date of last physical exam ____________

What operation have you had and when? ____________

Serious illnesses ____________

What Medication or drugs are you taking? ____________

Have you retained an attorney? ☐Yes ☐No **Litigation?**☐ Yes ☐ No ☐Maybe

INSURANCE DATA:

Name of person(s) responsible for payment ____________

Do you have insurance? ☐ **No** ☐ **Yes** **Company's Name** ____________

Please list all source of insurance:

- **Group Insurance** ____________ **Member No.** ____________
  Name

I understand and agree that health and accident insurance policies are in an arrangement between an insurance carrier and myself. Furthermore, I understand that this office 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 this office will be credited to my account on receipt. I permit this office to endorse so-issued remittance for he conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, and fees for professional services rendered me will be immediately due and payable.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me by the doctor or intern, affiliated with Chiropractic Wellness Group. I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks of treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, and is in my best interests. I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor or intern, affiliated with Chiropractic Wellness Group to perform such. I intent this consent from to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Signature ____________ **Date:** ____________ **Guardian or Spouse's Signature Authorizing Care** ____________ **Date:** ____________

Information Taken By: ____________ **Date:** ____________

-PLEASE COMPLETE THE INFORMATION ON THE REVERSE SIDE ALSO-

HEALTH QUESTIONNARIE: CHECK ANY OF THE FOLLOWING SYMPTOMS YOU AVE NOTICE SINCE YOUR ACCIDENT/INJURY

SYMPTOMS:

HEAD:
- □ Headache
- □ Entire head
- □ Back of head
- □ Forehead
- □ Temples
- □ Migraine
- □ Loss of balance
- □ Dizziness
- □ Ringing in ears

NECK:
- □ Stiff Neck
- □ Muscle spasms in neck
- □ Pain in neck
- □ Neck pain with movement

SHOULDER:
- □ Pain in shoulder joint (R-L)
- □ Pain across shoulders
- □ Bursitis (R-L)
- □ Arthritis (R-L)
- □ Can't raise arm
- □ Above shoulder level
- □ Over head
- □ Tension in shoulders

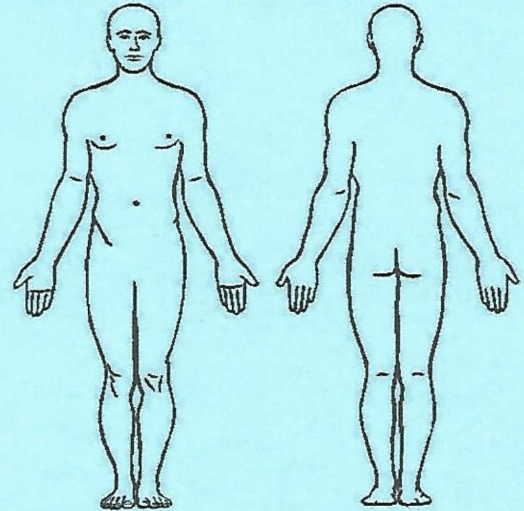
ARMS & HANDS:
- □ Pain in upper arm
- □ Pain in forearm
- □ Pain in hands
- □ Pain in fingers
- □ Sensation of pins & needles in arms
- □ Sensation of pins & needles in fingers
- □ Finger go to sleep
- □ Hands cold
- □ Loss of grip strength

MID-BACK:
- □ Mid-back pain
- □ Pain between shoulder blades
- □ Sharp Stabbing pain in mid-back
- □ Muscle spasms

LOWER BACK
- □ Lower back pain
- □ Lower back pain in sores when:
- □ working
- □ lifting
- □ stooping
- □ standing
- □ sitting
- □ bending
- □ coughing
- □ Lower back feels out of place
- □ Muscle spasms
- □ Arthritis

HIPS, LEGS & FEET:
- □ Pain in buttocks (R-L)
- □ Pain in hip joint (R-L)
- □ Pain down leg (R-L)
- □ Leg cramps
- □ Pins & needles in legs (R-L)
- □ Numbness of leg (R-L)
- □ Numbness of feet (R-L)
- □ Feet feel cold
- □ Cramps in feet (R-L)
- □ Swollen ankles (R-L)
- □ Swollen Feet (R-L)

Mark Areas of Pain
Mark Areas of Tingling/Numbness



CHEST:
- □ Chest pain
- □ Shortness of Breath
- □ Pain round ribs

GENERAL
- □ Nervousness
- □ Irritable
- □ Depressed
- □ Fatigue
- □ Generally feel run-down
- □ Loss of sleep
- □ Loss of weight

ABDOMEN:
- □ Nervous stomach
- □ Nausea
- □ Gas
- □ Constipation
- □ Diarrhea

FEMALE ONLY:
Date of last menses ______________

Are you pregnant?
Yes No

Briefly describe symptoms you are presently suffering from: ______________________________
____
____

Other Doctors seen for this/there conditions ______________________________

History of present injury – Date: ______________ Approximated hour ______________(AM)(PM)

Have you lost any days works? From ______________ To ______________

If other than auto injury, describe how injury occurred ______________________________
____

If auto injury fill out the following information: Driver______ Passenger______ Front______ Back ______

Patient's car was going: Direction ______________ Street or Road ______________

Closest bisecting street or road (if any) ______________Town______________

Numbers of autos involved in accident ______________ Numbers of person ______________

was patient moving __________ Stopped __________ Turning __________ Right or Left?__________

State exactly where your car was struck (side, rear, front, etc.) ______________________________

Did you see the accident coming? ______________ Were seat belts worn? ______________

Upon accident, which way were you thrown? ______________________________

Upon impact was there a "Blinding" or "explosion" sensation in the head? ______________________________

State which areas of your body were hurt immediately after the accident ______________________________
____

Were you able to get out the car and walk? ______________________________

Were you conscious at all times? ______________Could you move all parts of your body? ______________

Was a police report made? ______________________________

Was an ambulance called for you? ______________ Did you go to the hospital? ______________

If so, what was done: X-rays __________ Examination __________ Medications __________

How long were you in the hospital? ______________ Were you able to sleep that night? ______________

What discomfort did you have the first night? ______________________________

The next day? ______________________________