Welcome to Health for Life

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Thank you for choosing Health for Life for your Chiropractic needs. Please complete this form in ink. All information provided is confidential. If you have questions or concerns, please ask for assistance.

Name:____ DOB:_________________________ Sex: M or F

Address:_____________________________________City:_________________State:_______Zip:_________________

Phone: (_____)_____________________ Email:____

Patient Employer/School:____ Occupation:________________________

Marital Status:______________ Spouse's Name:_________________________________ Phone:(____)______________

Nearest Relative Not Living with You______________________________Phone (_____)____________________

Referral/How did you hear about us? ____

Have you ever received Chiropractic Care? Y or N If yes, when/where? ____________________________

Auto Insurance Information

Auto Carrier:____

Policy#:______________________________________Claim#____

Address:___________________________________City:______________________State:________Zip:_______________

Adjuster:____Phone: (____)___________________ext.________

Health Insurance Information

Person responsible for account:_____________________________________DOB:________________________

Relationship:______________________________ Phone: (____)___________________

Address:___________________________________City:__________________State:______Zip:_____________

Primary Insurance:____ (attach copy)

Secondary Insurance:____ (attach copy)

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide chiropractic care.

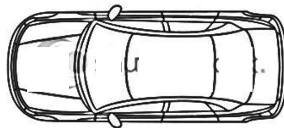
Patient Signature: ____ Date: ______________________

ACCIDENT HISTORY QUESTIONNARIE

PERSONAL INJRY PATIENT HISTORY

Name: ______________________ Date: ______________________

1. Date of Accident:______________ 2. Time: ______________ AM/PM
3. Driver of Car:______________________
4. Where were you seated? ______________________
5. Who owns the car?______________________
6. Year & Model of your car: ______________________
   Year & Model of other car: ______________________
7. What was the approximate damage done to your car? $ ______________
8. Visibility at time of accident: ☐ poor ☐ fair ☐ good ☐ other:
9. Road conditions at time of accident: ☐ icy ☐ rainy ☐ wet ☐ dark ☐ other (describe):
10. Where was your car struck?

FRONT  BACK

In your own words, please describe the accident: ______________________

____

____

11. Type of collision ☐ head on ☐ broad-side ☐ front impact ☐ rear-end in front ☐ rear impact ☐ non-collision

12. At time of the accident, recall what parts of your head or body hit what parts on the inside of your car.

____

13. Did you see the accident coming? ☐ Yes ☐ No 14. Did you brace for impact? ☐ Yes ☐ No
15. Were seatbelts worn? ☐ Yes ☐ No 16. Were shoulder harnesses worn? ☐ Yes ☐ No
17. Does your car have headrests? ☐ Yes ☐ No
18. If yes, what was the position of those headrest compared to your head before the accident? (circle one)
    Top of headrest even with bottom of head   Top of headrest even with top of head
    Top of headrest even with middle of neck
19. Was your car braking? ☐ Yes ☐ No 20. Was your car moving at the time of the accident? ☐ Yes ☐ No
21. If yes, how fast would you estimate you were going? ________ mph 22. The other car?________ mph
23. Head/Body position at the time of impact?
    ☐ Head turned left/right ☐ Head looking back ☐ Head straight forward
    ☐ Body straight in sitting position ☐ Body rotated right/left ☐ other:
24. As a result of the accident you were:
    ☐ Rendered unconscious ☐ In shock ☐ Dazed, circumstances vague ☐ Other:
25. How was your shoulder harness adjusted? ☐ Loose ☐ Tight
26. Were you wearing hat or glasses? ☐ Yes ☐ No
27. Could you move all parts of your body? ☐ Yes ☐ No
28. If no, why not?______________________
29. Were you able to get out of the car and walk unaided? ☐ Yes ☐ No

30. If not why? ______________________________

31. Did you get any bleeding cuts? ☐ Yes ☐ No If yes, where? ______________

32. Did you get any bruises? ☐ Yes ☐ No If yes, where? ______________

33. Describe how you felt immediately after the accident: ______________________

Later that day: ______________________________________

The next day: ______________________________________

34. Circle symptoms apparent since the accident:

Headache	Chest pain	Neck Pain/Stiffness	Mid back pain	Cold Feet
Anxious/Nervousness	Pain	Dizziness	Low back pain	Light sensitivity
Numbness in fingers	Loss of smell	Numbness in toes	Fainting	Sleeping problems
Facial Pain	Loss of memory	Fatigue	Breath shortness	Loss of taste
Irritability	Depression	Ringing in ears	Cold sweats	Loss of balance
Tension	Constipation	Cold hands	Clicking/Popping jaw	
Diarrhea	Other: ______________			

35. Occupation: ______________________ 36. Employer: ______________________

37. Have you missed time from work? ☐ Yes ☐ No

38. If yes, full time off work: ______________ to ______________

39. If yes, part time off work: ______________ to ______________

40. Did you seek medical help immediately after the accident? ☐ Yes ☐ No

41. If yes, how did you get there (ie Ambulance, police, drove yourself, etc.) ______________________

42. Doctor #1 Name: ______________ 43. First visit date: ______________

44. Were you examined? ☐ Yes ☐ No 45. Were X-rays taken? ☐ Yes ☐ No

46. Did you receive treatment? ☐ Yes ☐ No ☐ Medications ☐ Braces ☐ Collars

47. If yes, what kind of treatment did you receive? ______________________

48. What benefits did you receive from the treatment? ______________________

49. Date of last treatment? ______________

50. Doctor #2 Name: ______________ 51. First Visit Date: ______________

52. Were you examined? ☐ Yes ☐ No 53. Were X-rays taken? ☐ Yes ☐ No

54. Did you receive treatment? ☐ Yes ☐ No ☐ Medications ☐ Braces ☐ Collars

55. If yes, what kind of treatment did you receive? ______________________

56. What benefits did you receive from the treatment? ______________________

57. Date of last treatment? ______________

58. Do you have an attorney on this claim? ☐ Yes ☐ No

59. If yes, who? ______________________

Address: ______________________________________

City: ______________ State ________ Zip ________ Phone: ________

Illustrate how the accident happened:

PAST MEDICAL HISTORY: Circle those that apply, and please describe:

None related to current complaints | Hospital or operation | Auto Accidents | Work Accident
Illness | Other: ___

Describe: ___

___

___

FAMILY HISTORY: Please circle if it applies:

Tuberculosis	Kidney Disease	Spinal Disorder	Mental Illness	Epilepsy
Diabetes	Gout	Allergy	Arthritis	Hypertension
Cancer	Migraines	Heart Attack	Other: ___	

PERSONAL HISTORY: Circle if it applies, describe:

Single	Married	Divorced	Separated	Widow/Widower

Number of children: ___ Number of children at home: ___ Are you pregnant? Yes No

Medications, describe: ___

___

Disease, describe: ___

___

Other, describe: ___

___

SYSTEM REVIEW Circle all those that apply

GENITO-URINARY SYSTEM:

Bladder trouble	Excessive urination	Scanty urination	Painful urination	Disclosed urine

GASTRO-INTESTINAL SYSTEM:

Poor appetite	Excessive hunger	Difficult chewing	Difficult swallowing	Excessive thirst
Nausea	Vomiting food	Abdominal pain	Diarrhea	Constipation
Black stool	Hemorrhoids	Liver trouble	Weight trouble	Gall bladder trouble

NERVOUS SYSTEM

Numbness	Loss of feeling	Paralysis	Dizziness	Fainting
Headaches	Muscle jerking	Convulsions	Forgetfulness	Confusion
Depression				

CARDIO-VASCULAR SYSTEM

Chest pain	Pain over heart	Difficult breathing	Persistent cough	Coughing blood
Coughing phlegm	Rapid heartbeat	High blood pressure	Heart problems	Lung problems
Varicose veins	Other:			

EYES, EARS, NOSE, AND THROAT SYSTEM

Eye strain	Eye inflammation	Vision problems	Ear Pain	Ear noises
Ear discharge	Hearing loss	Breathing Difficulty	Nose bleeding	Nose discharge
Sore gums	Nose pain	Sore mouth	Sore throat	Hoarseness
Speech difficulty	Dental problems			

ACTIVITIES OF DIALY LIVING ASSESSMENT

Directions: The questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please circle one item in each section which most closely applies to you.

SECTION 1: PAINT INTENSITY

I can tolerate the pain I have without using pain killers
The pain is bad but I manage without taking pain killers
Pain killers give complete relief from pain
Pain killers give moderate relief from pain
Pain killers give very little relief from pain
Pain killers give no relief from pain. I do not use them

SECTION 2: PERSONAL CARE

I can look after myself normally without causing extra pain
I can look after myself normally but it causes extra pain
It is painful to look after myself and I am slow and careful
I need some help but manage most of my personal care
I need help every day in most aspects of self-care
I do not get dressed, wash with difficulty, and stay in bed

SECTION 3: LIFTING

I can lift heavy weights without extra pain.
I can lift heavy weights but it causes extra pain
Pain prevents me from lifting heavy weights off the floor,
But I can manage if they are conveniently positioned (on a table).
Pain prevents me from lifting heavy weights. I can manage,
light to medium weights if they are conveniently placed
I can lift only very light weights.

SECTION 4: WALKING

Pain does not prevent me from walking any distance
Pain prevents me from walking more than one mile
Pain prevents me from walking more than ½ mile
Pain prevents me from walking more than ¼ mile
I can only walk using a cane or crutches.
I am in bed most of the time and have to crawl to the toilet

SECTION 5: SITTING

I can sit in any chair as long as I like.
I can oly sit in my favorite chair as long as I like.
Pain prevents me from sitting for more than one hour.
Pain prevents me from sitting for more than 30 minutes.
Pain prevents me from sitting for more than 10 minutes.
Pain prevents me from sitting at all.

SECTION 6: STANDING

I can stand as long as I want without extra pain.
I can stand as long as I want, but it causes extra pain.
Pain prevents me from standing for more than one hour.
Pain prevents me from standing for more than 30 minutes.
Pain prevents me from standing for more than 10 minutes.
Pain prevents me from standing at all.

SECTION 7: SLEEPING

Pain does not prevent me from sleeping well.
I can sleep well only by using tablets.
Even when I take tablets I have less than 6 hours sleep
Even when I take tablets I have less than 4 hours sleep.
Even when I take tablets I have less than 2 hours sleep.
Pain prevents me from sleeping at all.

SECTION 8: SEX LIFE

My sex life is normal and causes no extra pain.
My sex life is normal but causes some extra pain.
My sex life is nearly normal but is very painful.
My sex life is severely restricted by pain.
My sex life is nearly absent because of pain.
Pain prevents any sex life at all.

SECTION 9: SOCIAL LIFE

My social life is normal and gives me no extra pain.
My social life is normal, but increases the degree of pain.
Pain has no significant effect on my social life apart from
My more energetic interest (dancing, etc.).
Pain has restricted my social life, and I do not go out as often.
Pain has restricted my social life to my home.
I have no social life because of pain.

SECTION 10: TRAVELING

I can travel anywhere without extra pain.
I can travel anywhere, but it gives me extra pain.
Pain is bad, but I manage journeys over 2 hours.
Pain restricts me to the journeys of less than one hour.
Pain restricts me to short necessary trips under a ½ hour.
Pain restricts me from traveling except to the doctor or
hospital.

CURRENT CHIEF COMPLAINTS Please circle the appropriate complaint areas.

SPINE

Low back Mid back Neck Pelvis

UPPER EXTREMITY

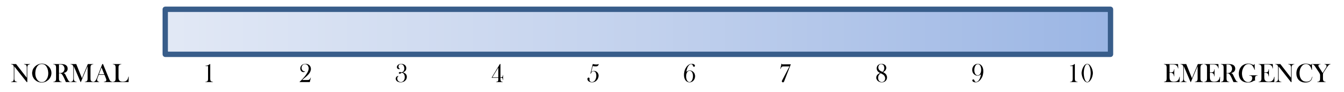
Shoulder R/L Arm R/L Elbow R/L Wrist R/ L Forearm R/L Hand R/L

LOWER EXTREMITY

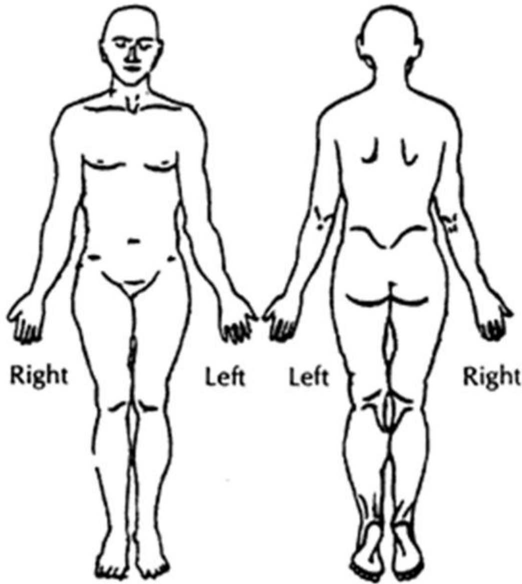
Hip R/L Thigh R/L Knee R/L Leg R/L Ankle R/L Foot R/L

SUBJECTIBE PAIN LEVEL:

On a scale of 1-10, circle your current pain level



NORMAL 1 2 3 4 5 6 7 8 9 10 EMERGENCY



Mark the areas of your body where you feel the described sensations. Use the appropriate symbol. Mark stress points of radiation. Include all affected areas

X NUMBNESS

+ BURNING

PIN &NEEDLES

= STABBING