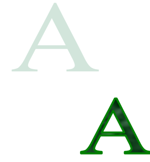

Welcome to Health for Life

Dr. Derrick Stanbridge D.C.

6033 S. Fashion Pointe Dr. #120 South Ogden, UT 84403
801.475.6800 Phone 801.475.6802 Fax

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? ___________________________

1. **Date of Collision**:____
2. Were you Driver or Passenger? Other Passengers or Driver in vehicle? Y or N
3. If you were the Driver, who was at fault? _________________________Did you receive a ticket? Y or N
4. Name/Names of Vehicle Occupants:____
   ____
   ____
   ____
5. Location of Accident: County__________________________City______________________State_________
6. Briefly Explain Accident:____
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____

Patient: Account Number:

7. Injuries sustained in this accident:____

8. Past Health History

   a. Previous illnesses, injuries, traumas, broken bones or surgeries:

Date	Type

9. Do you have Auto Insurance? Y or N   Private Health Insurance? Y or N
10. Do you have an Attorney? Y or N

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)

Attorney Information

Attorney:____Phone: (____)__________________ext.________

Address:________________________________City:_____________________State:________Zip:_____________

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:____________________________

Personal Injury Questionnaire

Name:____Date of Accident:________________________

1. What was your position in the car?
□ Driver: If Driver were your hands on the steering wheel? □ Left □ Right □ Both
□ Passenger: If Passenger, were you sitting in □ Front □ Left Rear □ Right Rear
2. Did your vehicle strike another vehicle? YES NO
3. Was your vehicle struck by another vehicle? YES NO
4. Angles of impact First Collision: □ Front □ Back □Left □ Right
Second Collision: □ Front □ Back □Left □ Right
5. Wear you wearing a seatbelt?
6. Did you brace for impact? YES NO □ braced with hands □ braced with feet
7. Which way were you facing at time of impact? □ Forward □ Right □ Left
8. Did you strike anything in vehicle at time of impact? YES NO

□Steering Wheel	□Dashboard
□Windshield	□ Roof
□Left Side Door	□Right Side Door
□Left Side Window	□Right Side Window

□Other:____

____

9. Did seat back bend/break? YES NO
10. Immediately following the accident, how did you think or feel?
□ dizzy/dazed □ disoriented □ unconscious □ nervous □ nauseous □upset □weak □Other:

____

11. Did you go to hospital? YES NO Were you admitted to the hospital? YES NO how long___
If you went to hospital when? □ At time of accident □ Next Day
How did you get to hospital? □ Ambulance □ Police Car □ Private Transportation
Name of Hospital?____
Attending Doctor:____

What treatment was given?

□ None	□Placed in Cervical collar
□X-rays, MRI, CT scan	□Given stitches
□IV fluids	□Pain medication

□given instructions for concussions □ instructed to follow-up with physican, surgeon
□referred to this office □ other: ____

____

____

12. Have you seen any other Doctors as a result of this accident? YES NO
Doctors Name:____

____

Patient: Account Number:

Chief Complaints or Symptoms

Name:______________________________ **Date:**___________

Neck Pain

(Check the areas that the pain runs into from neck)

□ none □ left shoulder □ left arm □ left forearm
□ left hand □ right shoulder □ right arm □ right hand
□ right forearm

□ Headache
□Migraine
□Upper Back Pain

Ringing in Ears? YES NO □ Left □ Right □ Both
Blurry Vision? YES NO □ Left □ Right □ Both
Wrist Pain? YES NO □ Left □ Right □ Both
Jaw Pain? YES NO □ Left □ Right □ Both

Low Back Pain

(Select the areas of radiation)

□ none □ buttocks □ left buttock □ right buttock
□ left thigh □ right thigh □left knee □ right knee
□left foot □ right foot

Hip Pain? □ Left □ Right □Bilateral
Knee Pain? □ Left □ Right □Bilateral
Foot Pain? □ Left □ Right □Bilateral

Additional Symptoms/Complaints

□ Numbness area:___________________________________
□Dizziness
□Nervousness
□Fatigue
□Anxiety
□Depression
□Excessive Irritability
□Jaw clenching
□Grinding of teeth at night
□Nightmares
□Difficulty Sleeping
□Fear of Driving or Riding in car
□Other:____

____

Doctors Notes

Patient:

Account Number:

____

13. Have you any lost time from work due to injuries? YES NO

If yes please give dates:____

Type of Employment:____

14. Have you had previous injuries or accidents? YES NO

Description of Previous Accidents Month/Year

(Write major or minor)

____

____

____

____

____

15. Do you have any residual pain from previous injuries? YES NO

16.How did you feel prior to your current condition? (Example 100%, 90% etc.):_______________________

Patient Signature :____ Date:_______________________

Patient: Account Number:

Medical Conditions: (Check all that apply)

- ☐ Arthritis
- ☐ Cancer
- ☐ Stroke
- ☐ Cancer Hypertension
- ☐ Cholesterol elevated
- ☐ Psychiatric illness
- ☐ Diabetes
- ☐ Skin Disorder

Surgeries: (Check all that apply)

- ☐ Appendectomy
- ☐ Joint replacement
- ☐ Cardiovascular procedure
- ☐ Laminectomies
- ☐ Cervical Disc Procedure
- ☐ Radical Prostatectomy
- ☐ Hysterectomy
- ☐ Transurethral Prostate Surgery

Allergies: (Check all that apply)

- ☐ Eggs
- ☐ Soy
- ☐ Fish & Shellfish
- ☐ Sulfites
- ☐ Milk or Lactose
- ☐ Wheat/Gluten
- ☐ Peanuts

Social History: (Check all that apply)

- ☐ Caffeine used occasionally
- ☐ Drink alcohol occasionally
- ☐ Exercise often
- ☐ Smoke more than 1 pack a day
- ☐ Caffeine used often
- ☐ Drink alcohol often
- ☐ Experience stress occasionally
- ☐ Wear seatbelts always
- ☐ Chew tobacco occasionally
- ☐ Exercise not al all
- ☐ Experience stress often
- ☐ Wear seatbelts never
- ☐ Chew tobacco often
- ☐ Exercise occasionally
- ☐ Smoke 1 pack or less per day
- ☐ Wear seatbelts usually

Family History: (Check all that apply)

- ☐ Arthritis (parent)
- ☐ Cholesterol (parent)
- ☐ Heart problems (parent)
- ☐ Psychiatric (parent)
- ☐ Thyroid (parent)
- ☐ Arthritis (sibling)
- ☐ Psychiatric (sibling)
- ☐ Thyroid (sibling)
- ☐ Cancer (parent)
- ☐ Diabetes (parent)
- ☐ High Blood Pressure (parent)
- ☐ Stroke (parent)
- ☐ Cancer (sibling)
- ☐ Diabetes (sibling)
- ☐ High Blood Pressure (sibling)
- ☐ Stroke (sibling)
- ☐ Cholesterol (silbing)
- ☐ Heart Problems (sibling)

Substance Use: (Check all that apply)

- ☐ Alcohol (past)
- ☐ Barbiturates (past)
- ☐ Crystal Meth
- ☐ Marijuana (present)
- ☐ Alcohol (present)
- ☐ Barbiturates (present)
- ☐ Heroin (past)
- ☐ Amphetamines (past)
- ☐ Cocaine (past)
- ☐ Heroin (present)
- ☐ Amphetamines (present)
- ☐ Cocaine (present)
- ☐ Marijuana (past)

Male Children: (Check all that apply)

- ☐ Under 6 years
- ☐ Under 10 years
- ☐ Under 19 years

Female Children: (Check all that apply)

- ☐ Under 6 years
- ☐ Under 10 years
- ☐ Under 19 years

Occupational Activities: (Check all that apply)

- ☐ Administration
- ☐ Construction
- ☐ Healthcare
- ☐ Household
- ☐ Military
- ☐ Teacher
- ☐ Business owner
- ☐ Daycare/childcare
- ☐ Heavy equipment operator
- ☐ Light manual labor
- ☐ Police/fire
- ☐ Truck driver
- ☐ Clerical/secretarial
- ☐ Executive/legal
- ☐ Heavy manual labor
- ☐ Manufacturing
- ☐ Professional services
- ☐ Computer user
- ☐ Food service industry
- ☐ Home serves
- ☐ Medium manual labor
- ☐ Retail worker

Recreational Activities: (Check all that apply)

- ☐ Backpacking
- ☐ Golf
- ☐ Soccer
- ☐ Weight lifting
- ☐ Biking
- ☐ Racket ball
- ☐ Swimming
- ☐ Boating
- ☐ Running
- ☐ Tennis
- ☐ Football
- ☐ Skiing
- ☐ Walking.

Patient: Account Number:

HAVE YOU HAD TROUBLE WITH ANY OF THE FOLLOWING: (Check all that apply)

Cardiovascular:	Present	Past	No
Poor circulation	o	o	o
High Blood Pressure	o	o	o
Aortic Aneurism	o	o	o
Heart Disease	o	o	o
Heart Attack	o	o	o
Chest Pain	o	o	o
High Cholesterol	o	o	o
Pace Maker	o	o	o
Jaw Pain	o	o	o
Irregular Heartbeat	o	o	o
Swelling of Legs	o	o	o

Genitourinary:	Present	Past	No
Kidney Disease	o	o	o
Lower Side Pain	o	o	o
Burning Urination	o	o	o
Blood In Urine	o	o	o
Kidney Stone	o	o	o
	o	o	o

Hematologic/ Lymphatic:	Present	Past	No
Hepatitis	o	o	o
Blood Clots	o	o	o
Cancer	o	o	o
Easy Bruising	o	o	o
Easy Bleeding	o	o	o

Respiratory:	Present	Past	No
Asthma	o	o	o
Tuberculosis	o	o	o
Shortness of Breath	o	o	o
Emphysema	o	o	o
Cold/Flu	o	o	o
Cough/Wheezing	o	o	o

Ears/Nose/Throat:	Present	Past	No
Dizziness	o	o	o
Hearing Loss	o	o	o
Sinus Infection	o	o	o
Nosebleed	o	o	o
Sore Throat	o	o	o
Difficulty Swallowing	o	o	o
Bleeding Gums	o	o	o

Eyes	Present	Past	No
Glaucoma	o	o	o
Double Vision	o	o	o
Blurred Vision	o	o	o

Integumentary:	Present	Past	No
Skin Ulcers	o	o	o
Skin Disease	o	o	o
Eczema	o	o	o
Psoriasis	o	o	o
Rashes	o	o	o

Allergic/ Immunologic:	Present	Past	No
Hives	o	o	o
Immune Disorder	o	o	o
HIV/AIDS	o	o	o
Allergy Shots	o	o	o
Cortisone Use	o	o	o

Gastrointestinal:	Present	Past	No
Gallbladder issues	o	o	o
Bowel Problems	o	o	o
Constipation	o	o	o
Liver Problems	o	o	o
Ulcers	o	o	o
Diarrhea	o	o	o
Nausea/Vomiting	o	o	o
Bloody Stools	o	o	o
Poor Appetite	o	o	o

Musculoskeletal:	Present	Past	No
Gout	o	o	o
Arthritis	o	o	o
Joint Stiffness	o	o	o
Muscle Weakness	o	o	o
Osteoporosis	o	o	o
Broken Bones	o	o	o
Joints Replaced	o	o	o

Neurological:	Present	Past	No
Stroke	o	o	o
Seizures	o	o	o
Head Injury	o	o	o
Brain Aneurysm	o	o	o
Numbness	o	o	o
Severe Headaches	o	o	o
Pinched Nerves	o	o	o
Parkinson's disease	o	o	o
Carpal Tunnel	o	o	o
Spinning/Balance			

Endocrine:	Present	Past	No
Thyroid Disease	o	o	o
Diabetes	o	o	o
Hair Loss	o	o	o
Menopausal	o	o	o
Menstrual Problems	o	o	o

Psychiatric:	Present	Past	No
Depression	o	o	o
Anxiety disorder	o	o	o
Unusual Stress	o	o	o

Constitutional:	Present	Past	No
Weight Loss/Gain	o	o	o
Energy Level Issue	o	o	o
Difficulty Sleeping	o	o	o

Patient:

Account Number: