

Patient Contact Information:

Last Name: _____ **First:** _____ **Initial:** _____ **Home Phone:** _____
Nick Name: _____ **Cell Phone:** _____
Address: _____ **Work Phone:** _____ **Ext:** _____
 City: _____ State: _____ Zip: _____ **Email:** _____
Birth Date: _____ **Gender:** (Male Female) **Marital Status:** (S M W D Partnered)
Occupation: _____ **Employer:** _____
Whom may we thank for referring you? (Insurance Phone Book Web Search Drive By Other: _____)

Partner/Parent/Guardian/Emergency Contact:

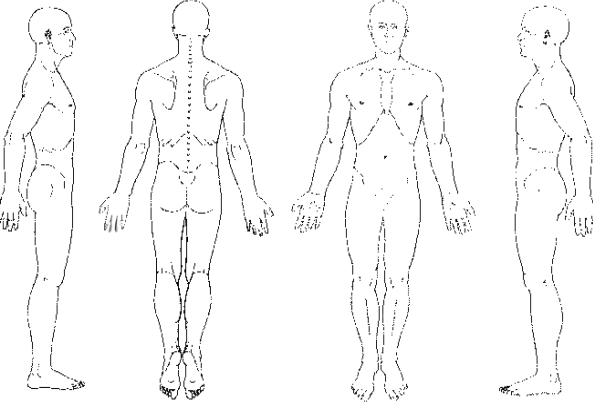
Name: _____ **Relationship:** _____
Address: _____ **Cell Phone:** _____
 _____ **Home Phone:** _____
 _____ **Work Phone:** _____

Patient Symptoms:

Over the past: (Days _____ Weeks _____ Months _____ Years _____)
My condition has been getting: Gradually Worse Rapidly Worse Staying About the Same Getting Better
Activities or movements painful to perform: Sitting Standing Walking Bending Lying Down Other: _____
Interferes with your: Work Sleep Daily Routine Recreation

I would describe my pain as: (circle as many as apply)
 CONSTANT FREQUENT INTERMITTENT OCCASIONAL
 VERY SEVERE SEVERE MODERATE DULL
 STABBING SHARP ACHING MILD
 BURNING TINGLING THROBBING NUMBNESS
 SHOOTING STIFFNESS SWELLING OTHER: _____

PLEASE INDICATE AREAS OF DISCOMFORT



What is your pain on a scale from 1(least) to 10 (severe) _____
How often do you have this pain? _____
Is it constant or does it come and go? _____
I have tried the following solutions for this problem:

New to Chiropractic: (No Yes) **Previous Chiropractic Care:** (No Yes)
Dr: _____ **When?** _____
For treatment of: _____
Was there a specific treatment that was successful? _____

Present Family Doctor: _____ **Phone Number:** _____

Other Doctors consulted for these health problems:
Dr. Name: _____ **When:** _____
Diagnosis: _____ **Treatment:** _____
How long did you see the Doctor? _____ **How frequently?** _____
Results: _____

PATIENT CONDITION

- NO YES **Were you knocked unconscious?** If yes, how long? _____
- NO YES **Did you feel pain immediately after the accident?** If No, when did the pain begin? _____
- NO YES **Were you examined by a Medical Professional for this condition?** _____
- NO YES **Were you hospitalized?** If yes, where and when: _____
- NO YES **Diagnostic Imaging:** X-ray Cat Scan MRI Ultrasound Other: _____
- NO YES **Have you lost any days of work?** Date from: _____ to: _____
- NO YES **Have you had previous complaints in the injured area?**

YOUR VEHICLE AND ACCIDENT DETAILS

Make/Model/Year of Vehicle: _____

Were you the: Driver Passenger Front Rear

Please briefly describe the accident: _____

What direction was the impact from? Front Rear Left Right

Other: _____

Placement of hands on the steering wheel? Both hands Only right hand Only Left Hand

Were you: Surprised by the impact **OR** Braced for Impact

NO YES Were you using a safety belt? Lap Shoulder

The head rest was in the: Low Mid-position High

NO YES Equipped with air bags? Did they inflate? NO YES

Was your car: Moving OR Stationary

NO YES Did your car hit another vehicle?

What speed were you traveling? _____

NO YES Were you hit by more than one car?

NO YES Did your car impact a structure? If yes please explain: _____

NO YES Did part of your body strike anything in the vehicle? If yes please explain: _____

NO YES Was your foot on the brake?

POLICE: Was a report filed? NO YES

Traffic violation issued to: _____

Officer Name: _____

Phone Number: _____

Case #: _____

PATIENT CONDITION

NO YES Were you knocked unconscious? If yes, how long? _____

NO YES Did you feel pain immediately after the accident? If No, when did the pain begin? _____

NO YES Were you examined by a Medical Professional for this condition? _____

NO YES Were you hospitalized? If yes, where and when: _____

NO YES Diagnostic Imaging: X-ray Cat Scan MRI Ultrasound Other: _____

NO YES Have you lost any days of work? Date from: _____ to: _____

NO YES Have you had previous complaints in the injured area?

Exercise/or Work Level:	Exercise:	Lifestyle:	Family:
<input type="checkbox"/> None <input type="checkbox"/> Daily <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy <input type="checkbox"/> Other: _____	<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light lifting to 20# <input type="checkbox"/> Heavy lifting +20# <input type="checkbox"/> Swimming <input type="checkbox"/> Biking <input type="checkbox"/> Jog/Run <input type="checkbox"/> Yoga	<input type="checkbox"/> Smoking (Pack/Day: _____) <input type="checkbox"/> Coffee/Caffeine (Cups/Day: _____) <input type="checkbox"/> Alcohol intake (Drinks/Week: _____) <input type="checkbox"/> High Stress (Reason: _____) <input type="checkbox"/> Other: _____	# Infant(s) under 2: _____ # Children: _____ # Care giver for: _____

Current Medication:	Adverse Side Effects or Allergies:
_____	_____

Injuries/Surgery:	Date/Year:	Description:
Falls/Accidents: <input type="checkbox"/> No <input type="checkbox"/> Yes _____		
Head Injuries: <input type="checkbox"/> No <input type="checkbox"/> Yes _____		
Broken Bones/Dislocations: <input type="checkbox"/> No <input type="checkbox"/> Yes _____		
Previous Hospitalizations: <input type="checkbox"/> No <input type="checkbox"/> Yes _____		
Surgeries: <input type="checkbox"/> Head <input type="checkbox"/> Neck/Throat <input type="checkbox"/> Back <input type="checkbox"/> Abdominal <input type="checkbox"/> Chest / Heart / Lungs <input type="checkbox"/> Other: _____		

Financial Responsibility and Insurance Information:

Auto Insurance Company: _____	Insurance Phone: _____
Claim Number: _____	Policy Number: _____
Claim Adjuster: _____	Phone #: _____
Attorney Name (If Applicable): _____	Phone #: _____

OTHER VEHICLE & DRIVER INFORMATION

Last Name: _____ First: _____ Initial: _____ Phone: _____

Make/Model/Year of Vehicle: _____

Insurance Company: _____ Insurance Phone: _____

Signature of Fact, Receipt of Notice Privacy Policies, Acknowledgement of Insurance Assignment and Release:

To the best of my knowledge and ability, I have provided true and complete information. I understand that I am financially responsible for all charges whether or not paid by insurance. By signing below I authorize the doctor, his designated staff and/or insurance company to release any information required for processing insurance claims. I assign any and all appropriate insurance benefits be paid directly to Dr. Bahm/Pine Lake Chiropractic Clinic, P.S. for services rendered.

I have received and reviewed, or had the opportunity to review, and understand and agree to the HIPPA *Notice of Privacy Practices of Pine Lake Chiropractic Clinic, P.S.*, which describes the Practice's policies and procedure regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

X _____

Signature of Patient

Printed Name _____ **Date** _____

Consent for Treatment of Minors or Dependents:

By my signature below, I hereby authorized Pine Lake Chiropractic Clinic, P.S. and their designated staff to administer care to my child or dependent as they deem necessary.

X _____

Signature of Parent or Guardian _____ **Date** _____ **Relationship to Patient** _____