Krieser Chiropractic
Family Wellness Center

NEW PATIENT INTAKE FORM -- Personal Injury **Today's Date**_____/_____/___

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_____ DOB_____/_____/_____ S/S_____-_____-_____

First MI Last

Address_____ City_____ State_____ Zip_____

Please check your preferred method of contact. Is it Ok to leave a message on the preferred number ❒*Yes* ❒*No*

❒Home Phone: _____ ❒Work Phone: _____

❒Cell Phone: _____ ❒e-mail address:_____

Would you like to receive appointment reminders? ❒ NO ❒YES Preferred Method: ❒Phone call ❒ Text ❒ E-mail

Height_____ Weight_____ Last known Blood Pressure: _____ *(Unsure? We can take a reading today)*

Do you smoke: ❒ No❒ Yes (If yes how often_____) If you quit: Start date: _____ End Date: _____

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

Ethnicity/Race: _____ Employed: ❒Full-Time ❒Part-Time ❒Student

Your Employer_____ Occupation_____

Business Address_____ City_____ State_____ Zip_____

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

Continued on back...

❍ ❒ Heartburn
❍ ❒ Ulcers
❍ ❒ Allergies
❍ ❒ Menstrual Pain
❍ ❒ Menstrual Irregularity
❍ ❒ Hot flashes
❍ ❒ Other _____
❍ ❒ Other _____

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

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

NATURE OF ACCIDENT

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

Relative speed of you car _____ (mph)
What was the site of impact on your car?
❒ Behind ❒ Front
❒ Driver's Side ❒ Passenger's Side

Relative speed of the other car _____(mph)
Where were you sitting at the time of impact?
❒ Driver
❒ Passenger …. ❒ Front ❒ Back

Were you wearing your seat belt?... ❒ No ❒ Yes
Were your brakes applied?……..… ❒ No ❒ Yes

Did your airbags deploy? ❒ 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)

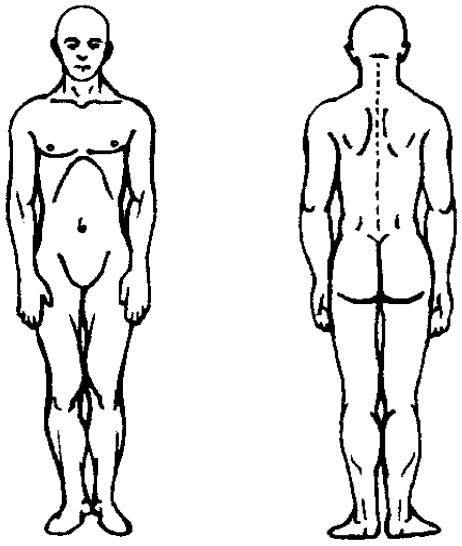
1) _____ 2) _____ 3) _____ 4) _____

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 (with dosage if known): ❒ None

_____

_____

List Allergies: _____

Surgical History: _____

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

I certify that the above information is true and accurate to the best of my knowledge

DATE: ____/____/____ **SIGNATURE:** _____

PARENT/GUARDIAN: _____