NEW PATIENT INFORMATION

Name _____ Today's Date_____

Date of Birth_____ Age ____ Sex: □ Male □ Female

Social Security # _____ Marital Status _____ Number of Children _____

Email _____ Home # _____ Work # _____

Cell # _____ Cell Provider (Verizon, T-Mobile,etc) _____

(Providing your cell provider allows us to send you appointment text reminders)

Address _____ City _____ Zip_____

Occupation _____ Employer _____ City_____

Type of work: □ Office/clerical □ Light Labor □ Moderate Labor □ Heavy Labor

Spouse Name _____ Spouse Date of Birth_____

Emergency Contact _____ Relationship _____ Phone _____

Name of person responsible for payment of this account _____

Have you ever received chiropractic care before? □ YES □ NO

If yes, how long ago?_____ For what?_____

Continue with vehicle collision paperwork on next page

ROMNEY CHIROPRACIC 24255 104th Ave SE Kent WA 98030 PH 253-277-4672

Vehicle Collision Questionnaire

Date of collision:_____ Time of Day: _____

Place of collision: _____

Was the collision on-the-job? □ Yes □ No

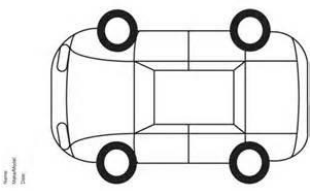
What type of vehicle were you in? (year, make, model)_____

What type of vehicle crashed with your vehicle? (year, make, model)_____

Road conditions at time of collision: □ Dry □ Wet □ Icy/Snow □ Gravel □ Dirt □ other_____

Where were you seated in the vehicle? □ Driver □ Passenger, _____

Where was your vehicle hit?:

Front  Rear

Just before the collision you were: □ Aware / braced for impact □ Surprised □ other_____

What was the LAST thing you remember before the collision? _____

What was the NEXT thing you remember after the collision? _____

Were you wearing a seat belt? □ YES, Shoulder and lap belt □ YES, Lap belt only □ NO

Did you have bruising or discomfort from the seat belt? □ YES □ NO

If YES, please describe: _____

Where was the **top** of the head restraint (head rest) **before** the collision?

□ above top of head □ below top of head □ equal to top of head □ I don't remember

Was the head restraint moved, shifted, or damaged during the collision? □ YES □ NO □ I don't remember

Did your head go back over the top of the head restraint? □ YES □ NO □ I don't remember

Does vehicle have an air bag? □ YES □ NO

If yes, did the air bag activate? □ YES □ NO

If yes, did you have any bruising, burning, or discomfort from the air bag? □ YES □ NO

If yes, please describe the airbag injury: _____

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At the time of impact your vehicle was: □ Stopped □ Moving about _____mph

If moving: □ speeding up □ maintaining steady speed □ slightly breaking □ moderately breaking

□ strongly breaking □ I don't know

Was your vehicle pushed from the impact?: □ No □ Yes, Describe, _____

Did your vehicle hit something else (a 2nd vehicle, cement barrier, etc) after the first collision: □ YES □ NO

If Yes, Describe: _____

At the time of impact the other vehicle was: □ Stopped □ Driving about _____mph

The other vehicle was: □ slowing down □ speeding up □ at a steady speed □ I don't know

What direction was your head pointed at the time of the collision? _____

What was the position of your hands at the time of collision? _____

What was the position of your feet at the time of collision? _____

What body parts struck something inside the vehicle? □ none □ _____

What bruises did you get from this collision? □ none □ _____

What cuts did you get from this collision? : □ none □ _____

Where you wearing a hat or eyeglasses/sunglasses during the collision? □ Yes □ NO

Is Yes, did they move or shift their position? Describe _____

Did your seat break or shift position from the collision? □ YES □ NO □ I don't know

What is the cost damage to the vehicle you were in? $_____

Please describe and/or draw, to the best of your knowledge, what happened during this collision:

Mark the boxes in columns 1 and 3 if you had any of these symptoms **at any point following the vehicle collision:**

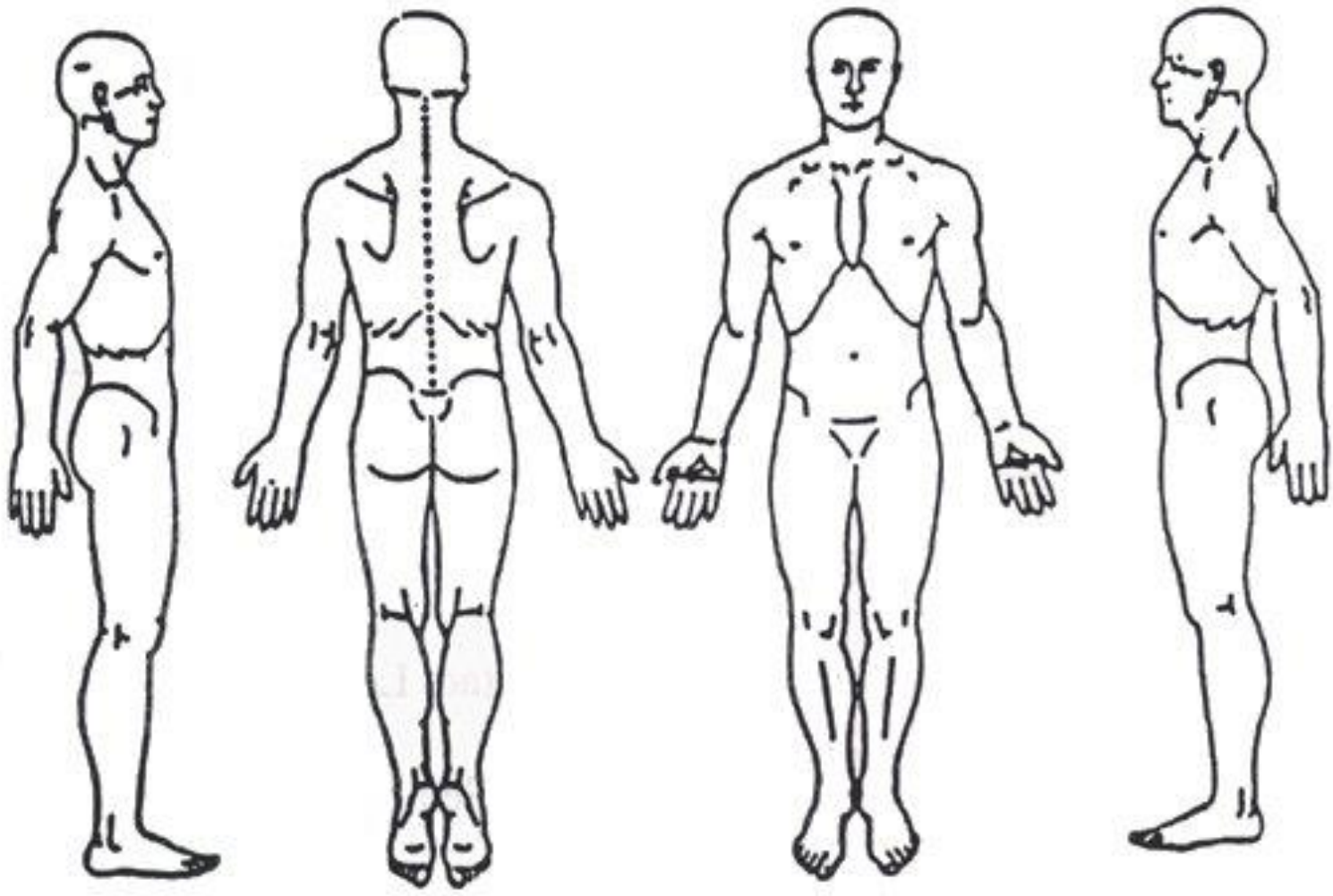
1.	Doctor's Notes	3.
□ Headache	□ Daily □ ____x/week D 1 2 3 4 F 1 2 3 4	□ Nervousness □ Anxiety
□ Neck Discomfort / Stiffness	□ Daily □ ____x/week D 1 2 3 4 F 1 2 3 4	□ Dizziness □ Light Headed □ Room Spinning □ Ear Ringing
□ Shoulder Discomfort / Stiffness	□ Daily □ ____x/week D 1 2 3 4 F 1 2 3 4	□ Difficulty Finding Comfortable Sleep Position □ Trouble Staying Asleep □ Trouble Falling Asleep
□ Arm / Hand discomfort	□ Daily □ ____x/week D 1 2 3 4 F 1 2 3 4	□ Fatigue □ Tiredness □ Irritability
□ Arm / Hand Numbness and/or Tingling	□ Daily □ ____x/week D 1 2 3 4 F 1 2 3 4	□ Nausea □ Vomiting
□ Chest / Rib Discomfort	□ Daily □ ____x/week D 1 2 3 4 F 1 2 3 4	□ Blurred Vision □ Double Vision
□ Upper Back Discomfort / Stiffness	□ Daily □ ____x/week D 1 2 3 4 F 1 2 3 4	□ Stuttering Speech □ Slurring Speech
□ Mid Back Discomfort / Stiffness	□ Daily □ ____x/week D 1 2 3 4 F 1 2 3 4	□ Change in Smell □ Change in Taste
□ Low Back Discomfort / Stiffness	□ Daily □ ____x/week D 1 2 3 4 F 1 2 3 4	□ Problems with coordination □ Poor Balance □ Dropping Things
□ Hip Discomfort	□ Daily □ ____x/week D 1 2 3 4 F 1 2 3 4	□ Light Sensitivity □ Noise Sensitivity
□ Leg / Foot discomfort	□ Daily □ ____x/week D 1 2 3 4 F 1 2 3 4	□ Increased Depression □ Increased Emotions
□ Leg / Foot Numbness and/or Tingling	□ Daily □ ____x/week D 1 2 3 4 F 1 2 3 4	□ Problems Finding the "right word", □ Difficulty with Math □ Difficulty Concentrating □ Difficulty with Names and Places
□ Jaw Discomfort	□ Daily □ ____x/week D 1 2 3 4 F 1 2 3 4	□ Other

Frequency (F1= 25%, F2= 50%, F3= 75%, F4=Constant) - Severity (D1= slight, D2=mild, D3=moderate, D4=severe).

BODY DIAGRAM

Please use the following symbols to mark the areas on the image below where you feel any described sensations

Dull Pain: NNN Stabbing/Cutting Pain: /// /// /// Burning: XXX Numbness: = = = Tingling: ::::: Cramping: SSS



In the 3 months (90 days) before the collision, did you have any neck or back pain? □ Yes □ No

If yes, Describe:_____

TREATMENT FOLLOWING THE COLLISION

Where did you go immediately after the crash? □ Home □ Work □ Clinic □ Other _____

How did you get there? □ By ambulance □ With my vehicle □ Another vehicle

Did you go to the Emergency Department (ER) or Urgent Care: □ YES □ NO

Location: _____

Medications prescribed: _____

X-ray? □ Neck □ Mid Back □ Lower Back □ Chest □ Arm/Leg. _____

CT Scan or MRI? Describe_____

Lab Work? Describe_____

Referral? □ None □ Chiropractic Doctor □ Physical Therapist □ Massage □ Primary MD □ Specialist

List any other healthcare providers, clinics, or therapists you have seen for this collision? □ None

Name of provider/clinic	Special Tests (x-ray, MRI, etc)	Start Date & Stop Date	Type of Treatment and Medications prescribed	Results

Are you currently taking medications prescribed or over the counter for your injuries? □ Yes □ No

If yes, describe:_____

PERSONAL HABITS & MEDICAL HISTORY

Do you drink alcohol? □ Yes □ No If yes, daily average _____

Do you drink coffee or tea? □ Yes □ No If yes, daily average _____

Do you drink soda/energy drinks? □ Yes □ No If yes, daily average _____

Have you smoked or used tobacco? □ Yes □ No If yes, how many years? _____ daily average now _____

How many hours of sleep per night? _____ How many hours of exercise per week? _____

How many vegetable servings daily? _____ How much water do you drink per day? _____

Name of primary care doctor / Clinic _____City _____

Current health problems: □ None _____

Current medications not related to the collision: □ None _____

What is your height? _____ What is your weight? _____ Are you pregnant? □ Yes □ No

Previous Auto Accident? □ No □ Yes, _____

Fracture/broken bone? □ No □ Yes, _____

Surgery? □ No □ Yes, _____

Work Injury? □ No □ Yes, _____

Sports / Other Injury? □ No □ Yes _____

In the last month, check if you have you had? □ unexpected weight loss □ viral / bacterial infection □ fever

□ difficulty with bowel movements □ difficulty with urination □ the "worst headache of your life"

□ **I have not had any of these things in the last month**

Do any family members (blood relatives) have these conditions? □ Diabetes □ Cancer □ Stroke

□ Heart Disease □ High BP □ Bleeding Disorder □ Neck/Low Back Pain □ Other, _____

If you have experienced any of the following conditions in the past mark a **"P"** in the box. If you are currently experiencing any of the following conditions please mark a **"C"**. (check all that apply)

	Heart attack		Prostate trouble		Arthritis		Gall bladder trouble
	Diabetes		Glaucoma		Fainting spells		Kidney stones
	Difficulty with urination		Bloody stools		AIDS		Asthma
	Stroke		Anemia		Constipation		Menstrual cramping
	Cancer		Ulcers		Diverticulosis		Shortness of breath
	Unexpected weight loss		Loss of memory		Chest pain		Sudden weight loss
	Gout		Diarrhea		General fatigue		Loss of hearing
	Nausea		Muscle cramping		Soreness in joints		Epilepsy
	Ears ringing		Headache		Migraine		Joint Replacement
	Dizziness		Tuberculosis		Syphilis		Concussion
	Other						

PATIENT SIGNATURE: _____ **DATE:** _____