AUTO INJURY QUESTIONNAIRE

Name_____ Age_____ Birth Date_____/_____/_____ Sex: □ M □ F
Address_____City_____State_____Zip_____
Home#_____ Cell#_____ Work#_____
SSN_____ Email _____ Who referred you to us? _____
Marital Status □ M □ S □ D □ W Number of Children_____ Are you Pregnant? □ Yes □ No
Height_____ Weight_____ Occupation_____ Full Time / Part Time
Employers Name_____ Employers Address_____
Your Auto Ins. Co._____ Policy #_____ Do you have Med Pay? □ Yes □ No
Name of your Health Insurance Co.: _____ Name of your Attorney: _____

NATURE OF ACCIDENT:

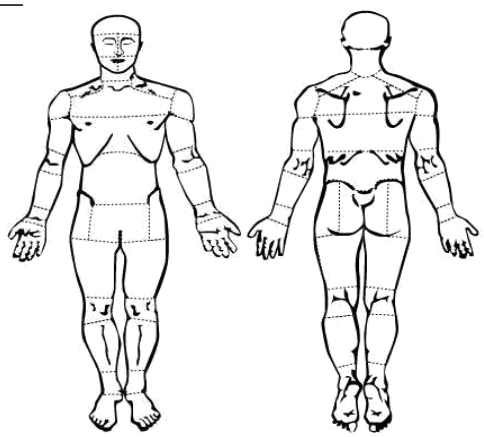
1. Date of Accident ___/___/___
2. In your own words, briefly describe the accident: _____
   _____
   _____
3. Were you □ Driver □ Front Passenger □ Left rear passenger □ Right rear passenger □ Other_____
4. Who hit who/what? □ You hit other vehicle □ Other vehicle hit you □ You hit object_____
5. Point of impact □ Head-on □ Left Front □ Right Front □ Rear-End □ Left Rear □ Right Rear
6. Your vehicle type □ Car □ Van □ Station Wagon □ Pick-up truck □ SUV □ Other_____
7. What was your vehicle doing at the time of the accident? □ Stopped at an intersection
   □ Stopped in traffic □ Stopped at light □ Making a right turn □ Making a left turn □ Parking
   □ Proceeding along □ Slowing down □ Accelerating □ Other_____
8. The other vehicle type □ Car □ Van □ Station Wagon □ Pick-up truck □ SUV □ Other_____
9. What was the other vehicle doing at the time of the accident? □ Stopped at an intersection
   □ Stopped in traffic □ Stopped at light □ Making a right turn □ Making a left turn □ Parking
   □ Proceeding along □ Slowing down □ Accelerating □ Other_____
10. Did you have a seat belt on? □ Yes □ No Did you have a shoulder harness on? □ Yes □ No
11. What was the direction of your head at time of impact? □ Straight □ Turned Right □ Turned Left
12. How many people were in the car with you? □ None □ One □ Two □ Three □ Four □ Other_____
13. Time of Accident_____ Road conditions at time of accident □ Icy □ Wet □ Sandy □ Dark □ Clean and Dry
14. Visibility at time of Accident □ Poor □ Fair □ Good
15. What was the position your headrest at time of impact? □ Up □ Down □ Unknown □ No head rests
16. Was the head restraint position altered by the impact? □ Yes □ No □ Unknown
17. Did driver side air bags deploy? □ Yes □ No Did passenger side airbags deploy □ Yes □ No
18. What was your hand position on the steering wheel? □ Both hands on □ One hand on □ Do not recall
19. Did you have pressure on the brakes? □ Yes □ No □ Do not recall
20. Did you see the accident coming? □ Yes □ No Were you braced for the impact? □ Yes □ No
21. Did your body strike the inside of your vehicle? □ Yes □ No *If yes, what part of your body?_____ hit what part of the vehicle?_____
22. Did your vehicle hit anything else after the crash? _____
23. Did you lose consciousness during the injury □ Yes □ No *If yes, how long_____
24. Did the police show up at the scene? □ Yes □ No Was a report filed? □ Yes □ No
25. Where did you go after the accident? □ Home □ Work □ Hospital ER □ Private Doctor
26. How did you get there? □ Drove self □ Somebody else □ Ambulance □ Police □ Other_____
27. Check off your symptoms right after and/or a few days following:

□ Headache	□ Dizziness	□ Nausea	□ Diarrhea	□ Anxious	□ Constipation	□ Sleep trouble
□ Low back pain	□ Cold feet	□ Confusion	□ Fatigue	□ Ringing in ears	□ Chest pain	□ Shortness of breath
□ Mid-back pain	□ Cold hands	□ Fainting	□ Depression	□ Pain behind eyes	□ Loss of smell	□ Hand numbness
□ Neck stiffness	□ Neck pain	□ Nervousness	□ Tension	□ Toe numbness	□ Irritability	□ Other_____

28. If you went to the hospital, were x-rays done? □ Yes □ No Was lab work done? □ Yes □ No
    Body parts x-rayed? _____ X-rays revealed? _____
    Lab work revealed? _____
29. Treatments: □ Cervical collar □ Ice □ Medications_____ □ Other_____

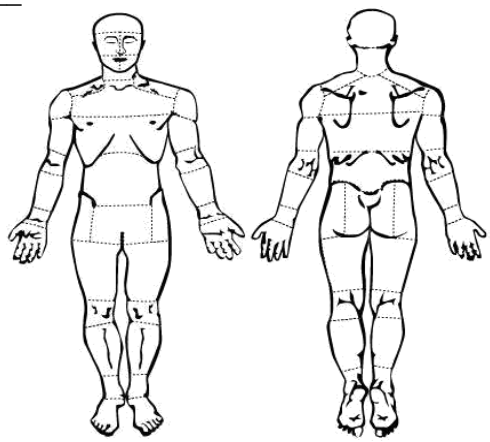
PLEASE DESCRIBE EACH AREA OF PAIN OR DISCOMFORT SEPARATELY AND COMPLETELY.

PRIMARY COMPLAINT: _____



Symptoms appeared: ☐ Gradually ☐ Suddenly
How long have you had this pain? _____ Years / Months / Weeks / Days
Mark an X on the picture to the right where you are having pain or discomfort --->
Type of pain:
☐Aching ☐Burning ☐Diffused ☐Dull ☐Numbness ☐Sharp
☐Shooting ☐Throbbing ☐Tightness ☐Tingling
How frequently do you have this pain? (Check one below):
☐Constant ☐Frequent ☐Intermittent ☐Occasional
Symptoms are aggravated by: _____
Symptoms are reduced by: _____
Rate the severity of your pain (Circle one): 1 2 3 4 5 6 7 8 9 10
What time of day is the pain most noticeable? _____

ADDITIONAL COMPLAINT: _____



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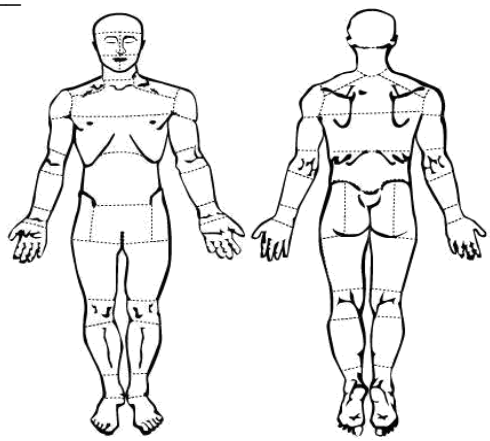

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HAVE YOU SEEN ANY OTHER DOCTORS FOR THIS CONDITION?

1) Name_____
Phone #_____
Dates of care_____
Tests/Treatments_____
Results _____

2) Name_____
Phone #_____
Dates of care_____
Tests/Treatments_____
Results_____

Prior Similar Symptoms:

☐ I have NOT had prior symptoms similar to my current complaints.

☐ My current complaints DID exist before, but have not been bothering me.

☐ My current complaints ALREADY existed and were worsened.

My most recent prior similar symptoms (if applicable) occurred…
☐ Months ago / ☐ Years ago or on date: ___/___/___

Has your history contributed to your current

☐ My history HAS contributed to my current symptoms.

☐ My history HAS NOT contributed to my current symptoms.

☐ I'm NOT SURE if my history has contributed to my current symptoms.

Write in any prior symptom history, not covered above:
_____

Please check all conditions below that you currently have or have had in the past

☐AIDS/HIV	☐Chicken Pox	☐Heartburn/Acid reflux	☐Menstrual Irregularities	☐Prostate Problems
☐Alcoholism	☐Chemical Dependency	☐Heart Disease	☐Migraine Headaches	☐Prosthesis
☐Allergies	☐Constipation	☐Heart Palpitations	☐Miscarriage	☐Rheumatoid Arthritis
☐Allergy Shots	☐Depression	☐Hepatitis	☐Mononucleosis	☐Ringing in the Ears
☐Anemia	☐Diabetes	☐Hernia	☐Multiple Sclerosis	☐Sinusitis
☐Appendicitis	☐Diarrhea	☐Herniated Disc	☐Mumps	☐Sleeping Problems
☐Arthritis	☐Difficulty Swallowing	☐Herpes	☐Nervousness/Anxiety	☐Thyroid Problems
☐Asthma/Short of breath	☐Dizziness	☐High Blood Pressure	☐Osteoporosis	☐Tonsillitis
☐Bleeding Disorder	☐Eating Disorder	☐High Cholesterol	☐Pacemaker	☐Tuberculosis
☐Breast Lump	☐Emphysema	☐IBS	☐Parkinson's Disease	☐Tumors/Growths
☐Bronchitis	☐Epilepsy	☐Kidney Disease	☐Pinched Nerve	☐Ulcers
☐Cancer	☐Glaucoma	☐Liver Disease	☐Pneumonia	☐Upset Stomach
☐Cataracts	☐Headaches	☐Measles	☐Polio	☐Vaginal Infections

Any other conditions not listed above: _____

PLEASE LIST ANY FRACTURES YOU HAVE HAD

Type_____ When_____ Doctor_____
Type_____ When_____ Doctor_____

PLEASE LIST ALL SURGERIES YOU HAVE HAD

Type_____ When_____ Doctor_____
Type_____ When_____ Doctor_____

PLEASE LIST ANY MEDICATIONS AND/OR VITAMINS YOU TAKE

What_____Frequency_____Doctor_____
What_____Frequency_____Doctor_____
What_____Frequency_____Doctor_____

PLEASE LIST ANY PREVIOUS ACCIDENTS/FALLS

What_____ When_____
What_____ When_____
Remarks_____

OCCUPATIONAL INFORMATION

Job Involves:
□ Sitting □ Standing □ Desk □ Counter □ Other _____ How long? _____
□ Lifting How much weight? _____ □ Bending □ Stooping □ Twisting □ Turning
Type of shoes □ High heels □ Boots □ Arch supports □ Other_____
How long do you speak on the telephone each day? _____ □ Traditional telephone receiver □ Headset
Physical activity at work: □ Sedentary □ Light manual labor □ Manual labor □ Heavy manual labor
Do any of your work activities aggravate your present main complaints? Please describe:

_____

HOW HAS THIS AFFECTED YOUR LIFE? **Circle one**

Have you missed work? YES NO If yes, how long?_____
Has the quality of your work been affected? YES NO
Are you able to do household chores? YES NO
Has this problem interfered with your social life? YES NO
Has it interfered with spending time with family and friends? YES NO
Has it interfered with your recreational activities? (Exercise, Golf, Tennis, etc.) YES NO
Please list any other daily activities/duties that are difficult for you due to the pain you're having.

_____

DISABILITY

Do you have a permanent disability rating? _____ Location_____ Date received_____
Rating Percentage_____

HEALTH HABITS:

☐ Smoking: _____ Packs per Week ☐ Alcohol: _____Drinks per Week
☐ Coffee/Caffeine: _____Drinks per Week ☐ High Stress Level: High/ Moderate/ Low Reason: _____
☐ Other Chemical Dependencies:_____

Exercise: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

Sleep: Hours per night_____ Type of mattress_____ Naps_____
Do you sleep on your ☐ Back ☐ Side ☐ Stomach
Please describe your sleep (ex. deep/restful, interrupted, etc.) _____

Any special diets?_____

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.

✕_____ _____
Signature Date

Terms of Acceptance

When a patient seeks chiropractic health care and when a chiropractor accepts a patient for such care, it is essential that both are speaking and working for the same goals. Chiropractic does NOT diagnose or treat disease. Chiropractic has only one goal: **To Locate, Analyze and Correct Spinal Interference to the Nervous System**. The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The SUBLUXATION (spinal misalignment producing nerve interference,) in and of itself, is a detriment to life and health. Correction of the subluxation through a specific chiropractic adjustment allows the body to function at its optimum level. This allows the INNATE healing power of the body to work at maximum efficiency to restore, maintain and promote natural health.

WE DO NOT DIAGNOSE CONDITION(S) OR DISEASE(S) OTHER THAN VERTEBRAL SUBLUXATIONS.
WE DO NOT OFFER TREATMENT OF CONDITION(S) OR DISEASE(S) OTHER THAN VERTEBRAL SUBLUXATIONS.
WE PROMISE NO CURE FROM ANY CONDITION(S) OR DISEASE(S).
THE CHIROPRACTIC ADJUSTMENT RESTORES LIFE AND HEALTH TO ITS FULLEST POTENTIAL!!!

I, having read the above statement and understanding it fully, do undertake chiropractic health care on this basis.

✕_____ _____
Signature Date

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By signing below, I indicate that a copy of Shoreline Family Chiropractic Notice of Privacy Practices has been made available to me and understand that my signature indicates my consent to the use and disclosure of protected health information by Shoreline Family Chiropractic as described in that notice.

✕_____ _____
Signature Date
(Legal Guardian's Signature if Minor)