CATER CHIROPRACTIC CLINIC

PATIENT INTAKE FORM

Date___________________

Name_____________________________________ Email ____________________________________

Address____ City____________________ State_____

Zip Code_______________ Home Phone #: ____________________ Cell Phone #: _______________

Date of Birth____________________ Social Security# _________________________________

( ) AUTO ACCIDENT ( ) WORK ACCIDENT ( ) SLIP & FALL

DATE OF ACCIDENT: ________________ DRIVER PASSENGER

HOW DID THE ACCIDENT OCCUR:

( ) STRUCK WHILE STOPPED ( ) STRUCK ON LEFT SIDE ( ) STRUCK FROM BEHIND
( ) STRUCK WHILE MOVING ( ) STRUCK ON RIGHT SIDE ( ) STRUCK ON FRONT END

Was there anyone else in the car with you? YES NO _________ Were you wearing a seatbelt? YES NO

Did you hit any objects in the car? __________ What part of your body did you hit? ______________________

Were you: Rendered unconscious Bleeding ____________ Cut _____________ Bruising ________________

When did you begin having pain? Right Away Next day __________________

Were you seen by Paramedics or Fire rescue at the scene? YES NO

Did you go to the hospital? YES NO When___________________________

How were you taken to the hospital?
( ) BY AMBULANCE ( ) DROVE YOURSELF ( ) BY RELATIVE OR FRIEND

Name of hospital: ____

What was done in the hospital?
( ) EXAMINATION ( ) X-RAYS ( ) CAST/ SPLINT ( ) CT SCAN___________
( ) WERE YOU GIVEN ANY PRESCRIPTIONS? NO YES WHAT TYPE___________________________

OTHER DOCTORS / TREATMENT

Have you seen any other doctors for this accident other than today? YES NO
If yes, Who did you see? Dr. _________________________ ( ) FAMILY PHYSICIAN ( ) CHIROPRACTOR

( ) ORTHOPEDIST ( ) NEUROLOGIST ( ) OTHER ______________________________

WORK HISTORY

Have you lost any time from work because of this accident? YES NO I AM UNEMPLOYED

If yes, how many days have you missed? _______________ Are you working now? YES NO

PAST AND CURRENT MEDICAL, FAMILY AND SURGICAL HISTORY

Have you been involved in any other accidents? YES NO WHEN: ___________________________________

ANY PERMANENT INJURIES: ____

Are you currently taking any medication? YES NO If yes, what medications __________________________

For What: ____

DO YOU HAVE ANY ALLERGIES TO MEDICATION? YES NO If yes, to what?__________________________

Have you had any surgeries? YES NO If yes, what type of surgery and when _______________________

Do you suffer from any condition that I should know about, or are you under the care of another physician for any condition(s)?

YES NO If yes, please explain____

Anyone in your immediate family suffer from: CANCER DIABETES HEART DISEASE HIGH BP
OTHER:____________ WHO: __________________

PRESENT COMPLAINTS

Have you had any of the following complaints since the accident?

( ) Headaches
( ) Dizziness
( ) Neck Pain
( ) Upper to Mid Back Pain

( ) Shoulder Pain Right / Left
( ) Knee Pain Right / Left
( ) Ankle Pain Right / Left
( ) Foot Pain Right / Left

( ) Low Back Pain
( ) Hip Pain Right / Left
( ) Tingling or Numbness in Arms / Hands / Fingers Right / Left
( ) Tingling or Numbness In Legs / Feet / Toes Right / Left

( ) Trouble sleeping
( ) Trouble performing household activities (please list below)
( ) Difficulty STANDING or SITTING for long periods
( ) Pain when LIFTING or BENDING

( ) OTHER PAIN____