Welcome to Fayette Chiropractic Center
Dr. Linda H. Katz

CASE INFORMATION

☐ Worker's Comp ☐ Personal

☐ Auto Accident ☐ Slip/Fall ☐ Other

Have you lost time from work due to your condition? ☐ Yes ☐ No | How much?

Who referred you to the clinic?

How did you find us? (i.e., internet website, walk-in, etc.)

GENERAL INFORMATION

Patient's Name: _____ Date of Birth: _____
Last First Middle

SSN: _____ Email Address: _____

Address: _____
City State Zip

Home Phone: _____ Cell Phone: _____

Occupation: _____ Company Name: _____

Company Address: _____
City State Zip

Employer's Phone: _____

Spouse's Name: _____ Date of Birth: _____
Last First Middle

Company Name: _____ Employer's Phone: _____

Company Address: _____
City State Zip

MEDICAL HISTORY

Do you have a history of:

☐ Heart trouble ☐ Stroke ☐ Cancer ☐ Diabetes ☐ Kidney disease ☐ Thyroid trouble
☐ Seizures ☐ Blood pressure

Is there any family history of:

Father's side:

☐ Heart trouble ☐ Stroke ☐ Cancer ☐ Diabetes ☐ Kidney disease ☐ Other _____

Mother's side:

☐ Heart trouble ☐ Stroke ☐ Cancer ☐ Diabetes ☐ Kidney disease ☐ Other _____

INSURANCE INFORMATION

Group Name: _____ Policy Number: _____

Group Number (if applicable): _____ Name of Primary Insured: _____

Primary Insured Social Security Number: _____

Secondary Insurance Group Name: _____ Policy Number: _____

Group Number (if applicable): _____ Name of Primary Insured: _____

Primary Insured's Social Security Number:

Signature _____ Today's Date: _____

Name: _____ Date: _____

THE ACCIDENT			
Date of accident:		Time:	a.m. – or – p.m.
What type of vehicle were you in?		What was the other vehicle type?	
Who hit who/what? (check one): ☐ You hit other vehicle ☐ Other vehicle hit you ☐ You hit object			
Point of impact on your vehicle (check one): ☐ Head-on ☐ Left front ☐ Right front ☐ Rear-end ☐ Left rear ☐ Right rear ☐ T-bone, right side ☐ T-bone, left side			
Amount of damage to your vehicle (check one): ☐ Mild ☐ Moderate ☐ Totaled			
Amount of damage to the other vehicle (check one): ☐ Mild ☐ Moderate ☐ Totaled			
Did you see the accident coming? ☐ Yes ☐ No		Were you braced for the impact? ☐ Yes ☐ No	
Did you have a seat belt on? ☐ Yes ☐ No		Does your vehicle have headrests? ☐ Yes ☐ No	
Was your headrest (check one): ☐ Even with the top of your head ☐ Even with the bottom of your head ☐ Middle of your neck			
What was the direction of your head at the time of impact? (check one): ☐ Facing straight forward ☐ Turned to the right ☐ Turned to the left			
Your position in vehicle: (check one) ☐ Driver ☐ Front passenger ☐ Left rear passenger ☐ Center rear passenger ☐ Right rear passenger ☐ Other			
Was your vehicle: (check one) ☐ Stopped at light/stop sign ☐ Slowing down ☐ Making right turn ☐ Making a left turn ☐ Making a U-turn ☐ Stopped in traffic ☐ Parking ☐ Proceeding along ☐ Other			
Visibility at time of accident (check one): ☐ Poor ☐ Fair ☐ Good			
Road conditions at time of accident (check one): ☐ Icy ☐ Wet ☐ Sandy ☐ Clean and dry			
Did your body strike the inside of the vehicle? ☐ Yes ☐ No			
If yes, what part of your body hit the car?			

AFTER THE ACCIDENT			
Did you experience any of the following during or immediately following the accident:			
Loss of consciousness? ☐ Yes ☐ No	If yes, how long?		
☐ Dizziness	☐ Dazed	☐ Nausea	☐ Vomiting
Did the police arrive? ☐ Yes ☐ No		Was an accident report completed? ☐ Yes ☐ No	
Where did you go after the accident? ☐ Home	☐ Work	☐ Hospital ER	☐ Private Doctor
Name of hospital, if you went there:			
How did you get there? ☐ Drove self	☐ Somebody else	☐ Ambulance	☐ Police
Were X-rays taken? ☐ Yes ☐ No		If yes, which body parts were X-rayed?	
Was lab work done? ☐ Yes ☐ No			
Were medications prescribed? ☐ Yes ☐ No	If so, what kind?		

Name: _____ Date: _____

SYMPTOMS AFTER THE ACCIDENT

Please check any complications you've experienced since the accident:

- ☐ Pain while sleeping
- ☐ Fainting
- ☐ Loss of balance
- ☐ Ringing in Ears
- ☐ Eye sensitivity to light
- ☐ Loss of taste
- ☐ Fatigue
- ☐ Cold sweats
- ☐ Intestinal gas
- ☐ Constipation
- ☐ Smoking
- ☐ Chest pain
- ☐ Nervous/Anxious
- ☐ Cold hands/feet
- ☐ Shooting head pains
- ☐ Sinus trouble
- ☐ Loss of smell
- ☐ Neck stiffness
- ☐ Propping or grating in neck
- ☐ Head feels heavy
- ☐ Muscle spasms

Please check any activities of your daily living which are difficult to perform since the accident:

- ☐ Bathing
- ☐ Washing hair
- ☐ Drying hair
- ☐ Combing hair
- ☐ Putting on clothes
- ☐ Putting on shoes
- ☐ Making bed
- ☐ Carrying large objects
- ☐ Carrying small objects
- ☐ Eating
- ☐ Preparing meals
- ☐ Sleeping
- ☐ Doing laundry
- ☐ Taking out trash
- ☐ Going to toilet
- ☐ Cleaning dishes
- ☐ Climbing stairs
- ☐ Concentrating
- ☐ Lifting items from raised surface
- ☐ Standing for long periods
- ☐ Sitting for long periods
- ☐ Walking for long periods
- ☐ Kneeling for long periods

HEADACHE SYMPTOMS

If you are experiencing headaches, what part of your head hurts? ☐ Front ☐ Top ☐ Sides ☐ Back

How often during the day or night do you experience these headaches?

Do the headaches prevent you from performing daily activities? ☐ Yes ☐ No

Pain intensity of your headaches (check one) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

10 = worst

What seems to cause your headaches?

What have you done to relieve the headaches?

NECK SYMPTOMS

☐ Left side ☐ Right side ☐ Both sides | Pain frequency in this area (% of the day)

Check all of the symptoms that apply to your pain: ☐ Dull ☐ Sharp ☐ Aching ☐ Shooting ☐ Spasm ☐ Throbbing ☐ Burning ☐ Numbing ☐ Tingling

Does the pain prevent you from performing daily activities? ☐ Yes ☐ No

Pain intensity in your neck (check one) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

10 = worst

Check all movements that cause pain to your neck: ☐ Bending forward ☐ Bending back ☐ Bending right ☐ Bending left ☐ Twisting right ☐ Twisting left ☐ Coughing ☐ Sneezing ☐ Straining ☐ Standing ☐ Sitting ☐ Lifting

Does pain radiate to: ☐ Right arm ☐ Left arm ☐ Right leg ☐ Left leg

What have you done to relieve these symptoms?

Name: _____ Date: _____

UPPER BACK SYMPTOMS

☐ Left side ☐ Right side ☐ Both sides | Pain frequency in this area (% of the day)

Check all of the symptoms that apply to your pain: ☐ Dull ☐ Sharp ☐ Aching ☐ Shooting ☐ Spasm ☐ Throbbing ☐ Burning ☐ Numbing ☐ Tingling

Does the pain prevent you from performing daily activities? ☐ Yes ☐ No

Pain intensity in your upper back (check one) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

10 = worst

Check all movements that cause pain to your upper back: ☐ Bending forward ☐ Bending back ☐ Bending right ☐ Bending left ☐ Twisting right ☐ Twisting left ☐ Coughing ☐ Sneezing ☐ Straining ☐ Standing ☐ Sitting ☐ Lifting

Does pain radiate to: ☐ Right arm ☐ Left arm ☐ Right leg ☐ Left leg

What have you done to relieve these symptoms?

MID-BACK SYMPTOMS

☐ Left side ☐ Right side ☐ Both sides | Pain frequency in this area (% of the day)

Check all of the symptoms that apply to your pain: ☐ Dull ☐ Sharp ☐ Aching ☐ Shooting ☐ Spasm ☐ Throbbing ☐ Burning ☐ Numbing ☐ Tingling

Does the pain prevent you from performing daily activities? ☐ Yes ☐ No

Pain intensity in your mid-back (check one) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

10 = worst

Check all movements that cause pain to your mid-back: ☐ Bending forward ☐ Bending back ☐ Bending right ☐ Bending left ☐ Twisting right ☐ Twisting left ☐ Coughing ☐ Sneezing ☐ Straining ☐ Standing ☐ Sitting ☐ Lifting

Does pain radiate to: ☐ Right arm ☐ Left arm ☐ Right leg ☐ Left leg

What have you done to relieve these symptoms?

LOWER BACK SYMPTOMS

☐ Left side ☐ Right side ☐ Both sides | Pain frequency in this area (% of the day)

Check all of the symptoms that apply to your pain: ☐ Dull ☐ Sharp ☐ Aching ☐ Shooting ☐ Spasm ☐ Throbbing ☐ Burning ☐ Numbing ☐ Tingling

Does the pain prevent you from performing daily activities? ☐ Yes ☐ No

Pain intensity in your lower back (check one) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

10 = worst

Check all movements that cause pain to your lower back: ☐ Bending forward ☐ Bending back ☐ Bending right ☐ Bending left ☐ Twisting right ☐ Twisting left ☐ Coughing ☐ Sneezing ☐ Straining ☐ Standing ☐ Sitting ☐ Lifting

Does pain radiate to: ☐ Right arm ☐ Left arm ☐ Right leg ☐ Left leg

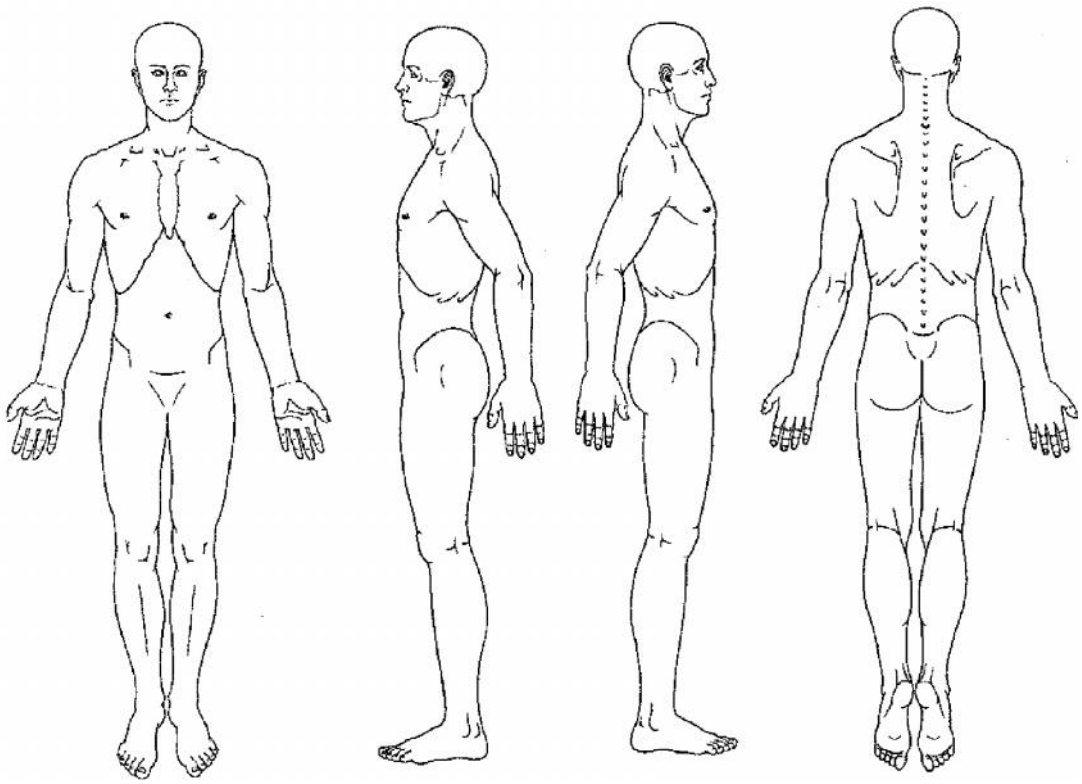
What have you done to relieve these symptoms?

Name: _____ Date: _____

OTHER AREA SYMPTOMS	
Other area?	
☐ Left side ☐ Right side ☐ Both sides	Pain frequency in this area (% of the day)
Check all of the symptoms that apply to your pain: ☐ Dull ☐ Sharp ☐ Aching ☐ Shooting ☐ Spasm ☐ Throbbing ☐ Burning ☐ Numbing ☐ Tingling	
Does the pain prevent you from performing daily activities? ☐ Yes ☐ No	
Pain intensity in this area (check one) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **10 = worst**	
Check all movements that cause pain to this area: ☐ Bending forward ☐ Bending back ☐ Bending right ☐ Bending left ☐ Twisting right ☐ Twisting left ☐ Coughing ☐ Sneezing ☐ Straining ☐ Standing ☐ Sitting ☐ Lifting	
Does pain radiate to: ☐ Right arm ☐ Left arm ☐ Right leg ☐ Left leg	
What have you done to relieve these symptoms?	

Please mark off the areas of your complaint on the diagram to the right with the following indicators:

NNN = Numbness
TTT = Tingling
BBB = Burning
CCC = Cramping
+++ = Throbbing
/// = Stabbing
000 = Pins & Needles
XXX = Other



Please list any previous accident(s) with the date(s) and injury type(s):

Please list all surgeries, injuries, falls, etc: