MARKET PLACE CHIROPRACTIC WELLNESS CENTER

MOTOR VEHICLE ACCIDENT/COLLISION INFORMATION

ABOUT THE PATIENT

Name: First________________Initial____Last__________________

Address:____

City:____________________________State:______Zip:__________

Date of Birth:________________Age:_______Gender ☐M ☐F

Home Phone:____

Cell Phone:____

Cell Provider (for Text reminders):____________________

E-Mail Address:____________________________________

Work Phone:________________Occupation:_______________

Employer:____

Marital Status: ☐Married ☐Single ☐Divorced

☐Separated ☐Widowed

ABOUT THE SPOUSE OR PARENT

Name:____

Cell Phone:____

Insurance Holder Date of Birth:_____________________

REFERRAL SOURCE

How did you hear about our office?

☐Internet (site)____________________________________

☐Patient referral (name)____________________________

☐Other referral source______________________________

EXPERIENCE WITH CHIROPRACTIC

Have you had chiropractic care before? ☐No ☐Yes

Reason for those visits:_____________________________

Previous Chiropractor's Name:________________________

Approximate Date of Last Adjustment:__________________

EXPERIENCE WITH MASSAGE

Have you had a massage before? ☐No ☐Yes

Reason for those visits:_____________________________

____

Previous LMP Name:__________________________________

Approximate Date of Last Massage:____________________

IN CASE OF EMERGENCY NOTIFY:

Name:____

Relationship:_______________________________________

Phone Number:_______________________________________

INSURANCE INFORMATION

Date of Injury/Incident:_____________________________

Your Insurance Company (PIP): ________________________

PIP Claim Number:___________________________________

PIP Adjuster's Name:_________________________________

Adjuster's Phone Number:_____________________________

Date PIP Application was filled out:___________________

If not filled out, why?:_______________________________

Amount of PIP Available:______________________________

Responsible Party Insurance (3rd Party):________________

3rd Party Claim Number:_______________________________

Responsible Party Name:_______________________________

Do you have an Attorney? ☐Yes ☐No

Attorney Name:_______________________________________

Attorney Address:_____________________________________

____

Attorney Phone Number:________________________________

Have you lost time from work? ☐Yes ☐No How much?______

POLICE

Did the police come to the accident site? ☐Yes ☐No

Were there any witnesses? ☐Yes ☐No

Was a police report filed? ☐Yes ☐No

Was a traffic violation issued? ☐Yes ☐No

If yes, to whom?_____________________________________

ACCIDENT/COLLISION SITE

Road/Street Name:____________________________________

City/State____

Nearest Intersection with road/street:__________________

Driving Conditions: ☐Dry ☐Wet ☐Icy ☐Other____________

Which direction were you headed?______________________

Speed you were traveling:_____________________________

*p.1 Provider's Initials:*____________

Patient Name: ____

YOUR VEHICLE

Make and Model of vehicle you were in:____________________

____

Were you wearing a seatbelt? ☐Yes ☐No

If Yes, what type? ☐Lap ☐Shoulder

Was the vehicle equipped with airbags? ☐Yes ☐No

If yes, did they inflate properly? ☐Yes ☐No

Did your seat have a headrest? ☐Yes ☐No

If yes, what was the position of the headrest?

☐Low ☐Midposition ☐High

OTHER VEHICLE

Make and Model of other vehicle:____________________

Which direction was other vehicle traveling?______________

Speed other vehicle was traveling:____________________

Name of other driver:____________________________

Address of other driver:__________________________

____

IMPACT

Did your vehicle impact another vehicle? ☐Yes ☐No

Did your vehicle impact a structure? ☐Yes ☐No

If yes, please explain:_________________________

Did any part of your body strike anything in the vehicle?

☐Yes ☐No If yes, explain:_________________________

Was impact from: ☐Front ☐Rear ☐Left ☐Right

☐Other____

At time of impact were you looking:

☐Straight ahead ☐Left ☐Right ☐Down ☐Up

Were both hands on the steering wheel? ☐Yes ☐No

If no, which hand was on the wheel? ☐Left ☐Right

Was your foot on the brake? ☐Yes ☐No

If yes, which foot was on the brake? ☐Left ☐Right

Date:____

PATIENT CONDITION

Were you: ☐Surprised by impact ☐Braced for impact

Were you unconscious immediately after the accident?

☐Yes ☐No If yes, for how long?__________________

Please describe how you felt immediately after the accident/collision:_________________________________

____

Did you go to the hospital or medical clinic? ☐Yes ☐No

When did you go? ☐Immediately after the accident

☐Next day ☐2 or more days after the accident

How did you get to the hospital?

☐Ambulance ☐Private transportation

Name of Hospital/Clinic:___________________________

Name of Doctor:_________________________________

Diagnosis:______________________________________

Treatment Received:______________________________

X-rays taken: ☐No ☐Yes Views:___________________

Other health care professionals seen for this injury:__________

____

Name/Address of Primary Care Provider and date of last visit:

____

____

Height:_________ Weight:________ Dominant Hand:________

Exercise: ☐Seldom ☐_X per week ☐Daily

How much water do you drink every day?________________

How many servings of Fruits & Vegetables do you eat daily?

____

Do you take Whole Food supplements? ☐No ☐Yes

Do you take Omega-3 fatty acid supplements? ☐No ☐Yes

Do you take Vitamin D3? ☐No ☐Yes Dosage____________

Do you take Probiotics? ☐No ☐Yes

Do you smoke or use tobacco? ☐No ☐Yes How much?_____

Do you drink alcohol? ☐No ☐Yes _____X per week

Do you wear orthotics or shoe inserts? ☐No ☐Yes

*p. 2 Provider's Initials:*___________

Patient Name: ____ Date: _______________

Describe in detail, in your own words, how the crash/accident happened: ____________

____

____

____

____

Current Conditions - Injuries - Symptoms:

Condition - Injury - Symptom	1.	2.	3.	4.
Date it began?				
In general, better with, when?				
In general, worse with, when?				
How would you describe the pain?	☐ ache ☐ dull ☐ sharp ☐ stabbing ☐ throbbing ☐ other ____________	☐ ache ☐ dull ☐ sharp ☐ stabbing ☐ throbbing ☐ other ____________	☐ ache ☐ dull ☐ sharp ☐ stabbing ☐ throbbing ☐ other ____________	☐ ache ☐ dull ☐ sharp ☐ stabbing ☐ throbbing ☐ other ____________
Does the pain or symptom radiate or go?	☐ yes ☐ no ☐ if yes, where? ____________	☐ yes ☐ no ☐ if yes, where? ____________	☐ yes ☐ no ☐ if yes, where? ____________	☐ yes ☐ no ☐ if yes, where? ____________
When awake - the pain/symptom is noticeable?	☐ >76% of the time ☐ 51-75% ☐ 26-50% ☐ <25%	☐ >76% of the time ☐ 51-75% ☐ 26-50% ☐ <25%	☐ >76% of the time ☐ 51-75% ☐ 26-50% ☐ <25%	☐ >76% of the time ☐ 51-75% ☐ 26-50% ☐ <25%

Condition - Injury - Symptom	5.	6.	7.	8.
Date it began?				
In general, better with, when?				
In general, worse with, when?				
How would you describe the pain?	☐ ache ☐ dull ☐ sharp ☐ stabbing ☐ throbbing ☐ other ____________	☐ ache ☐ dull ☐ sharp ☐ stabbing ☐ throbbing ☐ other ____________	☐ ache ☐ dull ☐ sharp ☐ stabbing ☐ throbbing ☐ other ____________	☐ ache ☐ dull ☐ sharp ☐ stabbing ☐ throbbing ☐ other ____________
Does the pain or symptom radiate or go?	☐ yes ☐ no ☐ if yes, where? ____________	☐ yes ☐ no ☐ if yes, where? ____________	☐ yes ☐ no ☐ if yes, where? ____________	☐ yes ☐ no ☐ if yes, where? ____________
When awake - the pain/symptom is noticeable?	☐ >76% of the time ☐ 51-75% ☐ 26-50% ☐ <25%	☐ >76% of the time ☐ 51-75% ☐ 26-50% ☐ <25%	☐ >76% of the time ☐ 51-75% ☐ 26-50% ☐ <25%	☐ >76% of the time ☐ 51-75% ☐ 26-50% ☐ <25%

IF NOT LISTED ABOVE, CHECK THE FOLLOWING SYMPTOMS NOTICED SINCE THE CRASH / ACCIDENT:

☐ *Headache*
☐ Neck Pain
☐ Neck Stiffness
☐ *Sleep Disturbance*
☐ *Depression*
☐ *Anxiety*
☐ *Fainting*
☐ *Muscle Spasms*
☐ *Fatigue*

☐ Middle Back Pain
☐ Chest Pain
☐ *Bruised Chest*
☐ *Bruising Anywhere*
☐ *Blurred Vision*
☐ *Sensitivity to Light*
☐ Upper Arm Pain (shoulder)
☐ Lower Arm Pain (elbow/wrist)
☐ Other Symptoms: ____________________________

☐ Lower Back Pain
☐ Lower Back Stiffness
☐ *Radiating Pain*
☐ Tingling in Legs
☐ Tingling in Arms
☐ *Jaw Pain (TMJ)*
☐ Upper Leg Pain (hip)
☐ Lower Leg Pain (knee/ankle)

☐ *Ears Ringing*
☐ *Buzzing in Ears*
☐ *Dizziness*
☐ *Loss of Smell*
☐ *Loss of Taste*
☐ *Any Burns*
☐ *Any Stitches*
☐ *Any Cuts*

Were there any symptoms which you had after the crash/accident that have now resolved? (please list)

____

____

*p. 3 Provider's Initials:*__________

Patient Name: ________________________________ Date: ______________

(If Applicable)

Have you had a repair estimate or has the vehicle you were in been repaired?

☐ Yes - If **Yes**, please provide a copy of the repair information

Was the repair done by an independent body shop? ☐ Yes ☐ No ☐ Not Sure

Did you get a second repair estimate? ☐ Yes ☐ No

Were the seatbelts replaced for all passengers in the crash? ☐ Yes ☐ No ☐ Not Sure

Were the anchors and seatbelt tensioners inspected for all passengers in the crash? ☐ Yes ☐ No ☐ Not Sure

Was there any damage to the seat(s) or head restraint(s)? ☐ Yes ☐ No ☐ Not Sure

Was the vehicle put on a hydraulic jack/lift? ☐ Yes ☐ No ☐ Not Sure

Was the frame inspected and/or repaired? ☐ Yes ☐ No ☐ Not Sure

☐ No - If **No**, when is it scheduled for repair? ______________________________

HEALTH HISTORY

Please list all prior serious illness and serious accidents: Month and Year City, State

____

____

____

Please list any recent x-rays, lab or other tests: Date Facility/Doctor

____

____

Please list all medications and dosage: Frequency For What Illness?

____

____

List any allergies to medications, foods or other: ____

Women Only: Are you pregnant? ☐ Yes ☐ No First day of last menstrual cycle:______________________

Do you take oral birth control? ☐No ☐Yes Are you nursing? ☐No ☐Yes Do you have breast implants? ☐No ☐Yes

Do you have painful periods? ☐No ☐Yes Do you have irregular cycles? ☐No ☐Yes

SURGERIES Spinal ☐ (Levels)______________________ Sinus ☐ Tonsils ☐ Throat ☐ Thyroid ☐ Colon ☐

Stomach ☐ Appendix ☐ Gallbladder ☐ Hysterectomy ☐ Other ________________________________

Do you smoke/chew? ☐ Yes ☐ No; How much?___________ Do you drink alcohol? ☐ Yes ☐ No; How much? ______________

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?

Cancer	☐ Yes	Transfusion	☐ Yes	Heart Disease	☐ Yes	Sciatica	☐ Yes
Bleeding	☐ Yes	Lung Disease	☐ Yes	Stroke	☐ Yes	Paralysis	☐ Yes
Colon Disease	☐ Yes	Tuberculosis	☐ Yes	Blood Pressure	☐ Yes	Polio/MS	☐ Yes
Stomach/Ulcers	☐ Yes	Asthma	☐ Yes	Kidney Disease	☐ Yes	Gout	☐ Yes
Hepatitis	☐ Yes	Seizures	☐ Yes	Diabetes	☐ Yes	Arthritis	☐ Yes
Anemia	☐ Yes	Thyroid Disease	☐ Yes	HIV/AIDS	☐ Yes	Drug Dependence	☐ Yes

AUTHORIZATION FOR CHIROPRACTIC CARE and/or MASSAGE THERAPY

I hereby authorize Market Place Chiropractic Wellness Center, PLLC, Dr. Jeffrey P. Clark, or whomever he may authorize as a Doctor of Chiropractic or a Licensed Massage Therapist to work with my condition through the use of chiropractic adjustments, massage therapy and any necessary ancillary care as is deemed appropriate. I agree that I will not hold Market Place Chiropractic Wellness Center, PLLC, or Dr. Jeffrey P. Clark, responsible for any pre-existing medically diagnosed condition(s) nor for any medical (non-chiropractic) diagnosis. Any treatment records, including X-Rays taken of my spine, are permanent records of Dr. Jeffrey P. Clark, dba: Market Place Chiropractic Wellness Center, PLLC, and will remain on file in accordance to State Law.

Patient Signature:____ Date:______________________

(Parent or legal guardian if patient is under 18 years old. Please PRINT your name and relationship to patient in space below.)

*P. 4 Provider's Initials:*__________