core chiropractic
DR. DEAN JACKS

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AUTO ACCIDENT / PATIENT REGISTRATION

Today's Date: _____ Cell Phone: _____

Patient: _____
Last Name First Name Middle Initial

Street Address: _____

City/State/Zip Code: _____

Sex: ☐ M ☐ F Age: ____ Birthdate: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #: _____ Email: _____

Emergency Contact Full Name: _____

Emergency Contact Telephone #: _____ Relationship: _____

PRESENT COMPLAINTS

(Please circle the appropriate ones)

Headache	Feet/Hands Cold	Unbalanced
Mental dullness	Depression	Fainting
Loss of memory	Rib pain	Blurred vision
Dizzy	Nervousness	Irritability
Ears ringing/buzzing	Eye strain/pain	Double vision
Upper back pain	Shortness of breath	Loss of smell
Lower back pain	Fear	Chest pain
Midback pain	Confusion	Neck pain
Pins and needles in hands right/left	Pins and needles in arms right/left	Pins and needles in legs right/left

Medical Implants: _____ **Medical alerts: _____**

Surgical Implants: _____ **Pregnancy: yes ____ no ____**

PAIN SCALE: Rate the severity of your pain by checking a box on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Excruciating Pain**

Patient Name: _____ **Date: _____**

Medications: *(please list all medications and supplements that you currently take)*

_____ _____ _____

_____ _____ _____

Allergies: *(please list all medications that cause allergic reaction)*

_____ _____ _____

_____ _____ _____

Smoking: _____ Yes _____ No If yes, _____ Packs per Day for _____ years

Alcohol: _____ Yes _____ No If yes, Number of drinks per week _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:
Surgery :_____ Date: _____

_____ _____

_____ _____

PERSONAL MEDICAL HISTORY & REVIEW OF SYMPTOMS

(Please indicate with an "X" any medical problems that you currently have or have had in the past.)

□ **NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders

□ asthma □ pulmonary embolism □ respiratory arrest
□ COPD □ pneumonia □ sleep apnea
□ emphysema □ tuberculosis □ other: _____

Cardiac / Heart and peripheral vascular disease

□ chest pain / angina □ high blood pressure □ irregular heartbeat, arrhythmia
□ heart attack □ heart murmur, valve disorder □ peripheral vascular disease
□ congestive heart failure □ mitral valve prolapse □ deep vein thrombosis
□ bleeding problems □ other_____

Neurologic Disorders

□ stroke or TIA □ Parkinson's □ cerebral palsy □ polio
□ peripheral neuropathy □ MS □ other: _____

Bone & Joint Disorders

□ osteoarthritis □ gout □ osteomyelitis
□ rheumatoid arthritis □ lupus □ ankylosing spondylitis
□ other: _____

Patient Name: _____ Date: _____

Gastrointestinal Disorders

□ peptic ulcer or stomach ulcer □ diverticulitis □ hepatitis - type _____
□ acid reflux, GERD □ irritable bowel □ inflammatory bowel disease
□ GI bleed □ liver disease □ other: _____

Genitourinary Disorders

□ urinary tract infection □ kidney problems □ dialysis, kidney failure
□ bladder problems □ kidney stones □ other: _____

Metabolic & Other Disorders

□ Diabetes x _____ years □ skin disorder □ depression
□ thyroid problems □ psoriasis □ tooth abscess, gingivitis
□ sickle cell disease □ any skin ulcer □ alcohol or drug dependency
□ high cholesterol or lipids □ anxiety □ other: _____

Cancer : any type -- please specify

_____

Other medical problems NOT included above (explain)

_____
_____

Family History: Please indicate with an "X" any significant family medical history or problems.

□ asthma □ tuberculosis □ sleep apnea
□ COPD or Emphysema □ lung □ heart attack, myocardial infarction
□ congestive heart failure □ irregular heartbeat □ arrhythmia
□ bleeding problems □ Peripheral neuropathy □ MS or Parkinson's
□ other neuro :_____
□ osteoarthritis □ Lupus □ gout
□ rheumatoid arthritis □ Other bone & joint: _____
□ acid reflux, GERD □ inflammatory bowel disease
□ hepatitis - Type _____ □ liver disease □ other GI :_____
□ kidney problems □ dialysis, kidney failure □ diabetes
□ psoriasis □ high cholesterol or lipids □ thyroid problems
□ sickle cell disease □ any skin ulcer □ Malignant hyperthermia

Cancer: any type -- please specify

_____

Other medical problems NOT included above (explain)

_____
_____

Patient Name: _____ Date: _____

AUTO ACCIDENT INFORMATION

Date of Accident: _____

Location of Accident: _____

Did you go to a hospital or another Physician for treatment after accident? No_____ Yes_____

Name of Hospital / Urgent Care / Physician: _____ Date Treated:_____

INSURANCE INFORMATION

Insured's Name: _____
Last Name First Name Initial

Auto Insurance Carrier: _____ ID # _____

Claim # _____ Policy #:_____

Name of Adjuster: _____ Telephone # _____

LEGAL INFORMATION

Attorney Name & Address:

_____

_____

Attorney Phone #: _____

Patient Signature: _____ Date: _____

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MOTOR VEHICLE COLLISION QUESTIONNAIRE

Please answer all questions completely:

1: Your Full Name and Address:

_____

_____

2: Phone Number: _____

3: Please describe the collision in your own words:

_____

_____

4: Where did the collision occur? City/Town: _____ State: _____

5: Date of collision: _____ Time: _____ AM / PM

6: Were you the: ____driver _____ passenger _____ pedestrian

7: If passenger, were you in the _____ front seat _____ right rear seat _____ left rear seat

8: What type of vehicle were you in? _____

9: What type was the other vehicle?

_____

10: Did your vehicle strike the other vehicle? ____yes _____ no

11: Was your car struck by the other vehicle? ____yes _____ no

12: What direction was your vehicle going? _____

13: What direction was the other vehicle going? _____

14: Was the impact from: ____ the front _____ the rear _____ the left side _____the right side

15: What was your approximate speed at the time of the impact? _____mph

16: What was the approximate speed of the other vehicle at the time of impact? _____ mph

17: What was the weather at the time of the collision? ____ dry _____ wet _____ icy

18: Was your vehicle in: _____ park _____neutral _____ in gear _____moving ____ stopped

19: Were your brakes being applied? ____ yes _____ no

20: Was your vehicle shoved: _____ forward _____ backward _____ sideways

21: Were you shoved: _____ forward _____ whipped backward

22: Did your seat have a head restraint (headrest?) _____ yes _____ no

Patient Name: _____ Date: _____

23: If yes, what was the position ____ low _____ mid-position _____high

24: Did your head ride over the headrest? _____yes _____ no

25: Did your hat/glasses end up in the back seat or rear window? _____ yes _____ no

26: Did any other part of your body hit the interior of the vehicle? _____yes _____ no

27: If yes, please specify: _____ seatbelt restraints _____ steering wheel _____ dashboard

_____windshield _____ side door _____ side window _____other _____

28: Which part of your body? _____ chest _____head _____ chin _____ face _____R / L knee

____ R / L shoulder _____ R / L hand _____other _____

29: Were you holding on to the steering wheel? ____yes _____ no

30: Did you brace your arms against the dash? _____ yes _____ no

31: Did you brace your legs against the floorboard? ____ yes _____ no

32: Was your ankle turned? _____yes _____ no

33: Did the vehicle go into a spin or roll as a result of the impact? _____ yes _____ no

If yes, explain: _____

34: How much damage was there to the outside of the vehicle? ____none _____some _____ a lot

35: How much damage was there to the inside of the vehicle? _____none _____some _____a lot

36: At the point of impact, where did you experience pain? Be specific:

_____

37: Immediately after the accident were you: _____ conscious _____ dazed _____ unconscious

38: If you lost consciousness, how long? _____

39: Were you wearing a seat belt? _____yes _____ no

40: Did the belt have a shoulder harness? _____ yes ____no

If yes, did it contribute to the pain you are experiencing? _____ yes _____no

41: At the time of impact were you: _____ looking straight ahead ____ looking to the right

_____ looking to the left _____looking down looking up

42: Did the seat break as a result of the impact? ____ yes _____ no

43: Were you braced for the impact? _____ yes _____ no

44: Were you surprised by the impact? _____ yes _____no

45: Did you go to the hospital? _____ yes _____ no

Patient Name: _____ Date: _____

46: If yes, when? _____right after the accident _____ next day Other _____

47: If yes, how did you get there? _____ ambulance Other: _____

48: If by ambulance, did the ambulance attendants place you in a: _____neck brace _____back brace

Other _____

49: Any medication or medical supplies given? _____

50: Did you have x-rays taken at the hospital? ____ yes ____ no

51: If you went to the hospital, please answer the following:

Name of hospital _____

Treatment Received _____

52: Have you had any similar problems before? ____ yes _____ no

If yes, explain: _____

53: Are you diabetic? _____ yes _____ no

54: Do you have high blood pressure? _____ yes _____no

55: Do you have low blood pressure? _____ yes _____ no

56: Do you have arthritis or degenerative joint disease? _____ yes _____no

57: What type of work do you do? _____

58: What are your job requirements? _____

59: Have you lost any days of work from this injury? _____ yes _____ no

If yes, give dates: _____

Patient Signature: _____ Date: _____

_____ Doctor Reviewed with Patient

Doctor Signature: _____ Date:_____