APPLICATION FOR TREATMENT

General Information

Name:_____
Address:_____
City/Zip:_____
Home phone #:_____
Social Security #:_____
Birth date:_____
Occupation:_____
Employer:_____
Work phone #:_____
Spouse:_____
Spouse's employer:_____
Spouse's work #:_____
Emergency contact::_____
Emergency contact #:_____
Today's date:_____
Date of injury:_____

Past Medical History

Surgeries and dates:_____
_____
_____
_____
_____
Fractures and dates:_____
_____
_____
Serious illness and dates:_____
_____
_____
Other injuries:_____
_____
_____
_____

Any prior history of current complaints:
_____
_____

Prior treatment by chiropractor and dates:
_____
_____

Current Medical History

Any current health problems:_____
_____
_____

Any current medications:_____
_____
_____
_____

Are you pregnant? ☐ Yes ☐ No

General Injury History

Was this crash on the job? ☐ Yes ☐ No
You were: ☐ Driver ☐ Front passenger
☐ Rear passenger ☐ Other
Vehicle driven by:_____
Your vehicle(yr.,make,model):_____
_____
Estimated speed at moment of crash:_____
☐Stopped ☐Slowing ☐Accelerating
Other vehicle(yr.,make,model):_____
Time of day:_____

Road conditions: ☐Dry ☐Damp ☐Wet
☐Snow ☐Ice ☐Other
Seatbelt: ☐Wearing ☐Not wearing
Did the airbag deploy: ☐Yes ☐No ☐NA
Where were you looking on impact:
☐Straight ahead ☐Up ☐Down
☐Right ☐Left ☐Combination of two
Braced for impact: ☐Yes ☐No
Hands: ☐One on wheel ☐Two on wheel
Brakes applied: ☐Yes ☐No
In your own words, describe what happened

_____
_____
_____
_____
_____
_____
_____

Crash diagram:

Were you aware that the crash was about to take place: ☐Yes ☐No

During the crash

Did any of your body strike any parts of the vehicle: ☐Yes ☐No
If yes, what part of your body stuck what part of the car:_____

_____
Did your car strike anything after the initial impact: ☐Yes ☐No
Wearing hat or glasses: ☐Yes ☐No
If yes, still on after crash: ☐Yes ☐No
Did you lose consciousness: ☐Yes ☐No
Was the police called: ☐Yes ☐No
Was a report made: ☐Yes ☐No

After the crash

Symptoms: ☐Headache ☐Dizziness
☐Nausea ☐Confusion/disorientation
☐Neck pain ☐Back pain ☐Numbness
If yes, where:_____
Arm pain ☐Yes ☐No
Leg pain ☐Yes ☐No
When did your pain appear: ☐Immediately
☐_____hours afterward ☐Next day
Where did you go after the crash: ☐Home
☐Work ☐Hospital
Mode of transportation:_____
Your medical Dr.:_____

Hospital visit

Xrays taken: ☐Yes ☐No
If yes, what body part:_____
Diagnosis:_____
Lab work: ☐Yes ☐No
Braces or supports: ☐Yes ☐No
Medications: ☐Yes ☐No