STANFIELD CHIROPRACTIC NEW PATIENT INFORMATION

NAME:(F)_____(M)_____(L)_____

Nickname:_____ Date Of Birth: _____

SOCIAL SECURITY #:_____ SEX: Male / Female

MARITAL STATUS: Single Married Widow Divorced Other

SPOUSES NAME(F)_____(M)____(L)_____Date Of Birth:_____

SPOUSES SOCIAL SECURITY # _____

HOME PHONE: _____CELL PHONE: _____

EMAIL: _____@ _____

ADDRESS: _____

CITY: _____ STATE:_____ ZIP: _____

Name of Relative Not Living with You:_____

Phone #:_____ Relation: _____

EMPLOYMENT STATUS: Full Time Part Time Not Employed Self Employed Retired

Active Military Student

EMPLOYER: _____WORK PHONE_____

OCCUPATON: _____

INSURANCE: _____

Policy #:_____ Group# _____

WHO MAY WE THANK FOR REFERRING YOU? _____

HAVE YOU SEEN/HEARD ABOUT OUR OFFICE ON:

Radio Billboard Television Magazine Newspaper

OTHER: _____

I clearly understand that if I am accepted as a patient at Stanfield Chiropractic, Inc. I authorize them to proceed with necessary treatment. Any risks regarding such treatment will be explained upon request. I also understand and agree that I am personally responsible for payment of charges for the services and supplies rendered to me. If insurance verification is obtained, insurance claims may be filed on your behalf. I understand that the filing of insurance is not a guarantee of payment, and I remain responsible for any balance due in it's entirety. I also understand that if I terminate my care and treatment, any fees for professional services rendered to me prior to termination of care will be immediately due and payable. In the extent of default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection. I hear by attest that the above and all following information is true to the best of my knowledge.

_____ _____ _____

Signature of Patient or Patient's Guardian Date Witness

Who is your primary doctor?

_____

What major surgeries have you had?

_____

What specialists have you seen? CIRCLE Physical therapist, Orthopedic Surgeon, Neurosurgeon, Neurologist, Psychiatrist, Psychologist, Pain Management, Massage, Rheumatologist, Dentist, ENT, Oncologist, Gastroenterologist, Cardiologist?
Give Name, Diagnosis and Treatment:

_____

_____

_____

What other Chiropractor have you seen?_____
Did the treatment help?_____What type of treatment was received?_____

_____

What supplements/vitamins/Meds do you take?_____

_____

What diagnostic tests have you had?
Xrays- date:_____location_____
MRI date_____location_____
CT date_____location_____
Bone Scan date_____location_____
Bone Density date_____location_____
Nerve Conduction date_____location_____
Other_____
Are your symptoms getting? Better Worse Same
Do you have metal in your body? Yes No Where?_____
Do you have a communicable disease? Yes No What disease?_____
Do you have active cancer? Yes No Type?_____
Do you have a history of cancer? Yes No Type?_____
Do you have a Pacemaker? Yes No
Do you have a history of Smoking? Yes No
Do you have a history of oral contraceptives? Yes No
Other health problems? Diabetic, heart problems, liver problems?_____

Are you experiencing any of the following stroke symptoms at this time?
YES NO Sudden difficulty speaking (slurred speech) understanding what people are saying?
YES NO Sudden onset of confusion or altered mental status, such as loss of consciousness, or not recognizing people who should be familiar?
YES NO Sudden numbness or tingling on one side of face or body or both?
YES NO Sudden onset of dizziness or unsteadiness, loss of balance or coordination, or both?
YES NO Sudden difficulty walking or standing upright?
YES NO Sudden severe headache?
YES NO Sudden severe unexplained upper-neck pain?
YES NO sudden trouble with vision or sight?

Please CIRCLE 1 number on EACH scale.

PAIN DISABILITY QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
Work normally — Unable to work at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
Take care of myself completely — Need help with all my personal care
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

3. Does your pain interfere with your traveling?
Travel anywhere I like — Only travel to see doctors
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

4. Does your pain affect your ability to sit or stand?
No problems — Can not sit/stand at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems — Can not do at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems — Can not do at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

7. Does your pain affect your ability to walk or run?
No problems — Can not walk/run at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

8. Has your income declined since your pain began?
No decline — Lost all income
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

9. Do you have to take pain medication every day to control your pain?
No medication needed — On pain medication throughout the day
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

10. Does your pain force your to see doctors much more often than before your pain began?
Never see doctors — See doctors weekly
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
No problem — Never see them
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference — Total interference
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
Never need help — Need help all the time
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression/tension — Severe depression/tension
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?
No problems — Severe problems
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

_____
Examiner

OTHER COMMENTS:

_____

With Permission from: Anagnostis C et al: The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. *Spine* 2004; 29 (20): 2290-2302.

INFORMED CONSENT FORM

EVERY TYPE OF HEALTH CARE IS ASSOCIATED WITH SOME RISK OF POTENTIAL PROBLEM. THIS INCLUDES CHIROPRACTIC HEALTH CARE. WE WISH YOU TO BE INFORMED ABOUT THE POSSIBILITY OF ANY POTENTIAL PROBLEMS ASSOCIATED WITH CHIROPRACTIC HEALTH CARE BEFORE CONSENTING TO TREATMENT. THIS IS CALLED INFORMED CONSENT.

CONSENT TO TREATMENT

THE FOLLOWING POINTS HAVE BEEN EXPLAINED TO ME TO MY SATISFACTION AND I HAVE HAD THE OPPORTUNITY TO DISCUSS THEM WITH THE DOCTOR AND/OR OTHER CLINIC PERSONNEL.

I. I UNDERSTAND THAT THE CHIROPRACTOR WILL USE HIS/HER HANDS OR A MECHANICAL DEVICE UPON MY BODY TO ADJUST A JOINT, AND THERE MAY BE AN AUDIBLE "POP" OR "CLICK" AS A RESULT OF JOINT MOVEMENT.

II. THE PRACTICE OF HEALTH CARE IS NOT AN EXACT SCIENCE, BUT RELIES UPON INFORMATION RELATED BY THE PATIENT, INFORMATION GATHERED DURING THE EXAMINATION (AND THE DOCTOR'S INTERPRETATION THEREOF), AS WELL AS THE DOCTOR'S JUDGEMENT AND EXPERTISE. CHIROPRACTIC HEALTH CARE IS NO DIFFERENT.

III. IT IS NOT REASONABLE TO EXPECT MY DOCTOR TO BE ABLE TO ANTICIPATE OR EXPLAIN ALL POSSIBLE RISKS AND COMPLICATIONS OF A GIVEN PROCEDURE ON ANY PARTICULAR VISIT, AND I WISH TO RELY ON THE DOCTOR TO EXERCISE PROFESSIONAL JUDGEMENT DURING THE COURSE OF ANY PROCEDURES WHICH S/HE FEELS AT THE TIME TO BE IN MY BEST INTEREST.

IV. THOUGH INFREQUENT, AS WITH ANY HEALTH PROCEDURE, THERE ARE CERTAIN COMPLICATIONS WHICH MAY ARISE DURING CHIROPRACTIC HEALTH CARE. THESE COMPLICATIONS INCLUDE; BUT ARE NOT LIMITED TO: SORENESS, SPRAINS/STRAINS, DISLOCATIONS, FRACTURES, DISC INJURIES, CEREBRAL-VASCULAR ACCIDENTS, PHYSIOTHERAPY BURNS, OR SOFT TISSUE INJURIES. THESE COMPLICATIONS ARE EXTREMELY RARE OCCURRENCES.

V. CHIROPRACTIC IS A SYSTEM OF HEALTH CARE DELIVERY; THEREFORE, AS WITH ANY OTHER HEALTH CARE DELIVERY SYSTEM, WE CANNOT PROMISE A CURE FOR ANY SYMPTOM, DISEASE, OR CONDITION AS A RESULT OF TREATMENT IN THIS FACILITY. WE WILL GIVE YOU OUR BEST CARE.

VI. I UNDERSTAND THAT THERE ARE OTHER FORMS OF TREATMENT, INCLUDING DRUGS AND SURGERY, WHICH COULD BE TREATMENT OPTIONS FOR MY CONDITION, BUT AT THIS TIME, I CHOOSE CHIROPRACTIC CARE.

I HAVE READ THE ABOVE CONSENT, OR IT HAS BEEN READ TO ME, HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS AND RECEIVE ANSWERS, AM COMFORTABLE WITH THE INFORMATION PROVIDED, AND CONSENT TO CHIROPRACTIC TREATMENT AND MANAGEMENT ON THAT BASIS. I HEREBY REQUEST AND CONSENT TO THE PERFORMANCE OF CHIROPRACTIC ADJUSTMENTS AND OTHER CHIROPRACTIC PROCEDURES INCLUDING VARIOUS MODES OF PHYSICAL THERAPY, AND IF NECESSARY, DIAGNOSTIC X-RAYS ON ME BY THE CHIROPRACTIC PHYSICIAN AND/OR ANYONE WORKING IN THIS OFFICE AUTHORIZED BY THE CHIROPRACTIC PHYSICIAN. I FURTHER UNDERSTAND THAT SUCH CHIROPRACTIC SERVICES MAY BE PERFORMED BY THE PHYSICIAN AND/OR OTHER HEALTH CARE PROVIDERS WHO MAY TREAT ME NOW, OR IN THE FUTURE AT STANFIELD CHIROPRACTIC. IN SIGNING THIS DOCUMENT, I IN NO WAY COMPROMISE MY PROTECTION AGAINST NEGLIGENCE.

PATIENT SIGNATURE _____ DATE_____

WITNESS SIGNATURE _____ DATE _____

STANFIELD CHIROPRACTIC

2300 SE 17TH STREET, BLDG. 1100

OCALA, FL 34471

ACKNOWLEDGMENT OF RECEIPT
OF
HIPPA NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the boxes below, I authorize contact for practice reminders by:

Mail ☐ Phone/Voicemail ☐ Text ☐

Email ☐ Email Address (if different from intake form):_____

FaceBook address _____.

By checking the boxes below, I authorize contact for birthday greetings or promotions about the practice by:

Mail ☐ Phone/Voicemail ☐ Text ☐

Email ☐ Email Address (if different from intake form):_____

FaceBook address _____.

☐ **By checking this box, I authorize the doctor to personally discuss with me products that may benefit my health or condition.**

_____ _____

Patient Name (please print) Date

_____

Name of Parent, Guardian or Patient's legal representative

_____

Signature of Patient, Parent, Guardian or Patient's legal representative

STANFIELD CHIROPRACTIC

JOSEPH STANFIELD D.C.
2300 SE 17TH STREET
BUILDING 1100 (TEALBROOKE)
OCALA, FL 34471
P 352-873-7563 F 352-873-7519

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____

ADDRESS:

_____

_____

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED TO

DR. JOSEPH STANFIELD
2300 SE 17TH STREET, BLDG. 1100
OCALA, FL 34471
FAX # 352-873-7519

_____/_____/_____
PATIENT'S DATE OF BIRTH

_____
PATIENT'S NAME (PLEASE PRINT)

_____/____/_____
PATIENT'S SIGNATURE DATE

www.STANFIELDCHIROPRACTIC.com

STANFIELD CHIROPRACTIC

JOSEPH STANFIELD D.C.

2300 SE 17TH STREET

BUILDING 1100 (TEALBROOKE)

OCALA, FL 34471

P 352-873-7563 F 352-873-7519

PATIENT PREGNANCY DISCLAIMER

This certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. I understand the clinical necessity of having X-rays taken at this time and grant permission for this procedure. In so doing, I release the doctor/clinic from responsibility for potential damage arising from this procedure.

At the present time,

_____ I am NOT pregnant.

_____ It is possible that I COULD BE pregnant.

_____ I AM pregnant.

The last date of my menstral cycle was: _____

_____ _____

Patient's Signature Date

_____ _____

Witness' Signature Date

RELEASE OF PERSONAL HEALTH INFORMATION

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____	_____
_____	_____
_____	_____

PERSONAL INJURY QUESTIONNAIRE

Name_____Today's Date:_____

Date of Injury_____Date of Birth::_____

Immediately After Accident Injury:

- Did you lose consciousness? ( ) Yes ( ) No
- How did you feel? ( ) Confused ( ) Dazed ( ) Dizzy ( ) Nervous ( ) Weak ( ) Other_____
- Did you immediately develop pain? ( ) Yes ( ) No
- If yes, describe what area_____

Other Doctors/Treatment you received:

- After the accident, where did you go? ( ) Hospital ( ) Home ( ) School ( ) Work ( ) Other_____
- Did you have Xrays taken? ( ) Yes ( ) No MRI? ( ) Yes ( ) No CT? ( ) Yes ( ) No
- If yes, name of facility_____
- Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list doctor's name and city_____

_____

- What type of treatment did you receive?_____

CIRCLE SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

Headache	Irritability	Numbness in Toes	Face Flushed	Feet Cold
Neck Pain	Chest Pain	Shortness of Breath	Buzzing in Ears	Hand Cold
Neck Stiff	Dizziness	Fatigue	Loss of Balance	Stomach Upset
Depression	Fainting	Sleeping Problems	Constipation	Head seems too Heavy
Back Pain	Loss of Smell	Pins & Needles in Arms	Fever	Light Bother Eyes
Nervousness	Loss of Memory	Pins & Needles In Legs	Loss of Taste	Cold Sweats
Tension	Ears Ring	Diarrhea	Blurred Vision	Double Vision
Reduced Vision	Vomiting	Impaired Vision	Painful Urination	

- Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting worse ( ) Same
- Home Therapy: ( ) Rest ( ) Activity ( ) Heat/Ice ( ) Massage ( ) Ointments ( ) Aspirin ( ) Other_____
- Are you getting any relief of pain from these therapies? ( ) Yes ( ) No
- Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, how much time?_____

_____

Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No

( )Daily Living ( ) Work ( ) Recreation ( ) Other_____

Number of people in your vehicle?_____

Have you retained an attorney? ( ) Yes ( ) No Name_____

Did you have any physical complaints BEFORE THE ACCIDENT ( ) Yes ( ) No If yes, briefly describe:

_____

_____

_____

Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, briefly describe:

_____

_____

_____

Surgeries: ( ) Appendectomy ( )Tonsils ( ) Hyst/Oophorectomy ( ) Hernia ( ) Prostate ( ) Gall Bladder

( ) Other_____

Personal or Family History :

Pacemaker ( ) Yes ( ) No Metal in your body ( ) Yes ( ) No Pregnant (If female) ( ) Yes ( ) No

Cancer ( ) Yes ( ) No If yes, indicate area and family member_____

Glaucoma ( ) Yes ( ) No If yes, indicate area and family member_____

Diabetes ( ) Yes ( ) No If yes, indicate area and family member_____

Smoker? ( ) Yes ( ) No If yes, _____per day Length of time_____

Drink Alcohol? ( ) Yes ( ) No If yes, daily ( ) Yes ( ) No

Current Medications you take:_____

_____

Vitamins:_____

_____

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Dear Patient:
This questionnaire will allow you to describe your automobile accident in detail. Please complete it carefully as the information provided will assist the doctor in evaluating and documenting your condition. THANK YOU.

PLEASE CIRCLE ALL CORRECT RESPONSES.

PATIENT NAME: **DATE:**

VEHICLE YOU WERE IN

1. Vehicle type?

Car Pickup
Van Truck
Station Wagon Bus
N/A Other

2. Vehicle size?

Subcompact Full-Size
compact Mini
Mid-Size Light
N/A Other

3. What was your location in the vehicle?

Driver Front Passenger Rear Passenger
Passenger Location: Left Middle Right
N/A Other _____

4. What was the vehicle you were in doing?

a. Vehicle stopped for

Traffic Light Intersection Stop Sign Traffic
Pedestrian Parked N/A
Other _____

b. Vehicle slowing down for

Traffic Light Intersection Stop sign Traffic
Pedestrian Turning Parking
N/A Other_____

c. Vehicle moving

Slowly Moderately Fast
___ MPH Accelerating
N/A Other_____

d. Vehicle doing other

Other_____

5. What damage did the vehicle you were in sustain?

Minimal Moderate Extensive Totaled
Unsure Other

IF OTHER VEHICLES INVOLVED IN ACCIDENT

1. First Vehicle To Strike Vehicle You Were In

a. Vehicle type?

Car Van Bus Pickup
Station Wagon
Other_____

b. Vehicle size?

Compact Subcompact Mini
Mid-Size Full Size N/A
Other_____

c. How did this vehicle strike the vehicle you were in?

d. What damage did this vehicle sustain?

Minimal Moderate Extensive
Unsure N/A Totaled Other
Head On From Right From Left From Rear
Sideswiped on right Sideswiped on left

2. Second Vehicle To Strike Vehicle You Were In

a. Vehicle type?

Car Pickup
Van Truck
Station Wagon Bus
Other, SUV

b. Vehicle size?

Subcompact Full-Size
Compact Mini
Mid-Size
Other

c. How did this vehicle strike the vehicle you were in?

Head On From Right From Left Rear Ended
Sideswiped On Right Sideswiped On Left
N/A Other

d. What damage did this vehicle sustain?

Minimal Moderate Extensive Totaled

3. Describe Other Vehicles To Strike Vehicle You Were In

Vehicle Type: How it struck: Vehicle Size: Damage:

4. Were traffic citations issued as a result of the accident?

No Citations issued Driver of other vehicle
Unsure
You Driver of vehicle you were in

C. CONDITIONS AT TIME OF ACCIDENT

1. What time of day did the accident occur?

Daylight Dawn Dusk Night
Other

2. What was the condition of the road?

Dry Damp Wet Snow Covered
Icy N/A Other_____

3. Visibility

a. What was the visibility at impact

Good Poor Fair Poor N/A Other_____

b. If visibility was poor, why?

Sun Light Darkness Rain Snow
Fog Traffic
N/A Other_____

D. AT MOMENT OF IMPACT

1. Were you prepared for the accident?

Accident a complete surprise Aware of impending collision
And braced for impact

2. Foot On Brake Pedal

a. Was your foot on brake pedal at impact? Yes no

b. Was it knocked off pedal by impact? Yes no

3. Use Of Restraints

a. Restraint Belts

1. Were you wearing a restraint belt? Yes no

2. What type of restraint belt were you wearing?

Shoulder-Lap Belt Shoulder Belt Lap Belt

b. Headrests

1. Was vehicle equipped with headrests? Yes no

2. What position was the headrest in?

Low Middle High Don't Know N/A

c. Air Bags

1. Was vehicle equipped with air bags?

Yes No Unsure

2. Did the air bags deploy? Yes no

4. Your Body

a. What was your body position at impact?

Straight Slouched Forward Rotated: Right Left
Don't Recall Other

b. What direction was your body thrown?

Forward\Backward Backward\Forward Sideways
Across Vehicle Outside Vehicle Under Vehicle
Don't Recall Other

5. Your Head And Neck

a. What position were your head/neck in at impact?

Straight Tilted Forward Rotated: Right Left
Don't Recall Other

b. Through what motion were your head/neck pitched?

Forward\Backward Backward\Forward Sideways
Don't Recall Other:

E. RESULT OF IMPACT

1. Which objects in the vehicle did the force of the collision cause your body to strike?

a. Head

Steering wheel	Dashboard	Windshield
Right side door	left side door	Armrest
Right Window	Left window	Headrest
Ceiling	Console	Shift lever
Front Seat	Rear view mirror	N/A
Other:		

b. Right Upper Extremity (Arm)

Steering wheel	Dashboard	Windshield
Right side door	left side door	Armrest
Right Window	Left window	Headrest
Ceiling	Console	Shift lever
Front Seat	Rear view mirror	N/A
Other:		

c. Left Upper Extremity (Arm)

Steering wheel	Dashboard	Windshield
Right side door	left side door	Armrest
Right Window	Left window	Headrest
Ceiling	Console	Shift lever
Front Seat	Rear view mirror	N/A
Other:		

d. Torso

Steering wheel	Dashboard	Windshield
Right side door	left side door	Armrest
Right Window	Left window	Headrest
Ceiling	Console	Shift lever
Front Seat	Rear view mirror	N/A
Other:		

e. Right Lower Extremity (Leg)

Steering wheel	Dashboard	Windshield
Right side door	left side door	Armrest
Right Window	Left window	Headrest
Ceiling	Console	Shift lever
Front Seat	Rear view mirror	N/A
Other:		

f. Left Lower Extremity (Leg)

Steering wheel	Dashboard	Windshield
Right side door	left side door	Armrest
Right Window	Left window	Headrest
Ceiling	Console	Shift lever
Front Seat	Rear view mirror	N/A
Other:		

2. Did your body strike any other objects?

Description Of Other Objects Your Body Hit:

F. ADDITIONAL INFORMATION

Additional Information About Your Automobile Accident:

Patients Or Guardian Signature: **Date:**

_____ _____

NAME: DATE

SUBJECTIVE HISTORY: In your own words, please describe your problem and area of pain and complaint.

MARK THE AREA on the body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected area.

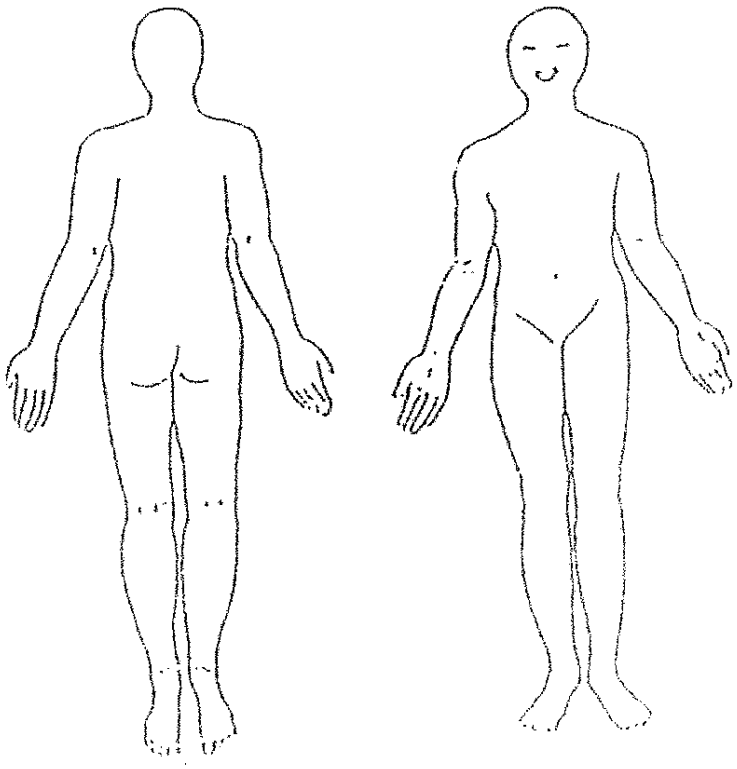
NUMBNESS ====

PINS AND NEEDLES oooooo

BURNING xxxxxx
xxxxxx

STABBING ///////

BACK FRONT



Patient_____#_____ Date _____

Review of Systems

Please check if you have/had problems.

REVIEW OF SYSTEMS

MUSCULOSKELETAL

Rheumatoid Arthritis	Yes ☐	No ☐
Gout	Yes ☐	No ☐
Osteoporosis	Yes ☐	No ☐
Cancer	Yes ☐	No ☐
Weakness	Yes ☐	No ☐
Spasm	Yes ☐	No ☐

Other_____

NEUROLOGICAL

Fainting	Yes ☐	No ☐
Stroke	Yes ☐	No ☐
Seizure	Yes ☐	No ☐
Numbness	Yes ☐	No ☐
Tremor	Yes ☐	No ☐

Other_____