AUTO ACCIDENT INITIAL HISTORY FORM

Name ____ Date ______________

Address ____________________________City _______________State _______Zip _______
Cell Phone _____/_____/________ Work _____/_____/_______ ext:____ Home _____/_____/_____
E-Mail address (emergencies + newsletters, never shared)______________________________
Date of Birth ________/_______/________Age ___________ Height ___ft.____in. Weight _____
Marital Status M S W D Name of Spouse ____
Children? Y N Names/Ages of Children ____
Employer ____________________________________Occupation ___________________________
Emergency Contact Person ______________________Relation ___________________________
Address ____________________________City _______________State _________Zip _______
Phone _______/_______/________ Who referred you here? ______________________________

ACCIDENT HISTORY

Date of Accident ____/_____/_____ Time of Accident _____ ☐ AM ☐ PM Where?_______________________
Details of the Accident ____

____
Make/Model/Year of your Vehicle________________________ Make/Model/Year other vehicle__________________
Driver or Passenger? _______ ☐Lap belt ☐Shoulder Belt ☐Both ☐No Seat Belt Worn Passengers? **Y N** Number___
How far is the top of the headrest from the top of your head? Approximately______inches ☐Above ☐Below ☐ Not Sure
How far away is the headrest from the back of your head? Approximately ______inches away ☐ Not Sure
Were police at the accident scene? ☐Yes ☐No Is there an accident report? ☐Yes ☐No Road: ☐Wet ☐Dry ☐Icy
Did you go to the hospital? ☐ Yes ☐ No By ambulance? ☐ Yes ☐ No
List exams and tests you received at the hospital ____

____
Diagnosis, home treatment, medication by hospital? _____________________________________
Were you ☐Aware of the approaching collision prior to impact, or did it ☐Catch you totally by surprise?
Any cuts or bruises from this accident? ____
Did you lose consciousness (black out) upon impact? ☐Yes ☐No How long were you out? ___________
Did you experience a flash of light/explosion in your head, or "see stars"? ☐Yes ☐No
Was your vehicle stopped at the time of impact? ☐Yes ☐No Was your vehicle ☐Slowing down ☐Gaining speed
☐Traveling at a steady rate Was your foot on the brake? ☐Yes ☐No
☐Automatic transmission ☐Standard transmission Was the car in gear? ☐Yes ☐No
Was the other vehicle stopped at the time of the accident? ☐Yes ☐No
Was this vehicle ☐Slowing down ☐Gaining speed ☐Traveling at a steady rate
Was the trunk of your body pointed straight forward at the time of collision? ☐Yes ☐No
If no, what direction was it turned? ____
Was your head pointed straight forward at the time of collision? ☐Yes ☐No
If no, what direction was it turned? ____
Did any body parts strike something in the car? ____
What parts of the vehicle broke? ☐Windshield ☐Front Seat Back ☐Steering Wheel ☐Other__________
What is the estimated cost of damage to your vehicle?_____________________________________
Please list the symptoms caused by this accident.

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

Overall, at this time, is your condition: ☐ Becoming worse ☐ Remaining the same ☐Improving
Please list other doctors or health care practitioners you have seen for this accident.
1. ______________________________
2. ______________________________
3. ______________________________
Are you currently taking any prescription drugs or over the counter drugs? ☐ Yes ☐ No (List Below)

____

____

Are you currently taking any vitamins or supplements? ☐ Yes ☐ No (List Below)

____

Have you stopped or changed your exercise program due to your accident? ☐ Yes ☐No
If so, what modifications have been made? ______________________________
What else are your problems preventing you from doing? Sports ____________ Hobbies ____________
Family/Kids ____________ Work ____________ Other ____________

Before this accident, were you suffering from any of the symptoms above? ☐ Yes ☐ No (If yes, please explain)

____

Prior to this accident, have you been involved in any similar types of injuries? ☐ Yes ☐ No (List Below)
If yes, when   Did you recover?   Any residual symptoms?

____

WORK HISTORY

At the time of this injury did you have a job? ☐ Yes ☐ No
Employer/Address ____________________ Occupation ____________________
Did you miss any work because of your injuries? ☐ Yes ☐ No From:___/___/___ To:___/___/___
Returned to work on: ____/____/____ Light or Full Duty? ____________________
Did you lose your job because of your injuries? ☐Yes ☐ No Did you change jobs because of your injuries? ☐ Yes ☐ No
Explain your job requirements, including positions and postures: ____________________

Have you seen any other chiropractors? Y N Name:____________________
Location:____________ Reason/diagnosis: ____________________
Any surgeries in your past? (include dates)____________________

____

Who is your primary physician? Name: ____________________ Location: ____________
When is the last time you visited your physician? Date:____________ Reason: ____________
Have you ever smoked? Y N Do you smoke now? Y N
If yes, how long, how much, and when did you quit? ____________________
Please list previous accidents/injuries, including major childhood traumas with dates and hospitalizations.

____

____

What childhood illnesses have you had (measles, chicken pox, etc.)? ____ Usual Other ____________

FAMILY HISTORY

Do any of your blood family have, or had, any of the following?

PROBLEM	YES	NO	PROBLEM	YES	NO
Chronic Back/Neck Pain	☐	☐	Stroke	☐	☐
Surgery	☐	☐	Heart Problems	☐	☐
Scoliosis	☐	☐	High Blood Pressure	☐	☐
Diabetes	☐	☐	Arthritis	☐	☐

Other ______________________________
Have you ever suffered a stroke, heart attack, or vascular disease? ☐ Yes ☐ No
Has anyone in your family suffered a stroke, heart attack, or vascular disease? ☐ Yes ☐ No (List Below)

____

Females: Do you take birth control pills? ☐Yes ☐No When did you start?____________
Have you ever taken birth control pills in the past? ☐ Yes ☐ No If yes, for how long (dates)?____________

Check any of the following conditions you have had or do have:

__ Allergies __ Drug Allergies __ Eczema __ Neck Pain
__ Sinus Problems __ Other Skin Problems __ Mid Back Pain
__ Asthma __ Headaches __ Low Back Pain
__ Anemia __ Migraines __ Shoulder Pain L R
__ Arthritis __ Heart Disease __ Elbow Pain L R
__ Cancer __ Heart Attack __ Hand Pain L R
__ Depression __ Menstrual Problems __ Hip Pain L R
__ Diabetes __ Multiple Sclerosis __ Leg Pain L R
__ Digestive Problems __ Stroke __ Knee Pain L R
__ Drug Abuse/Addiction __ Weight Problems __ Foot Pain L R
__ Alcoholism __ Ringing in Ears __ Carpal Tunnel L R
__ Stress __ Dizzy/Balance Problems __ Other ____________________

Are your parents alive? **Y N** If alive, what is their state of health? ____________________
If deceased, cause of death: ____________________
Siblings, ages, and health: ____________________

☐ Yes ☐No Any personality/emotional changes? If so, what? ____________________
☐ Yes ☐No Any changes to your sense of smell?
☐ Yes ☐No Do you see spots or any disturbances to your vision?
☐ Yes ☐No Does your heart feel like it races?
☐ Yes ☐No Any changes in bowel/bladder function? If so, what? ____________________
☐ Yes ☐No Any changes in sexual function? If so, what? ____________________
☐ Yes ☐No Have you noticed any short or long-term memory changes?
☐ Yes ☐No Any changes in your energy level such as fatigue?
☐ Yes ☐No Do you have any muscle twitches?
☐ Yes ☐No Do you exercise regularly? If so, what kind of exercise? ____________________

Are you a healthy eater? **Y N** An unhealthy eater? **Y N** Somewhere in-between? **Y N**
Can you eat anything you want? **Y N** If not, what do you avoid? ____________________
Do you drink regular soda? **Y N** Diet soda/drinks? **Y N** If yes, how many/day? ____________
Do you consume caffeine (coffee, soda, tea)? **Y N** If so, how much? ____________________

CONSENT TO TREATMENT AUTHORIZATION

By my signature below, I certify that the above information is correct. I authorize Fuller Chiropractic, P.C. to perform an examination, take x-rays if necessary, and administer chiropractic treatment. I authorize Fuller Chiropractic to contact other health care providers I have to coordinate my care, and to release information to my other providers for coordination of care, and to release my health information for insurance reimbursement purposes.

Patient Signature **(X)** ____________________ Date ____________

INSURANCE ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

I hereby instruct and direct ____________________ Insurance Company to make payment directly to: **FULLER CHIROPRACTIC, 576 Main Street, Woburn, MA 01801,** the professional or chiropractic benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.
A photocopy of this Assignment shall be considered as effective and valid as the original dated at Woburn, Massachusetts this ________ day of ______________ 20_____.

Patient Signature **(X)** ____________________

By my signature below, I understand that if my health insurance denies the charges, I am responsible for payment of my bill.

Patient Signature **(X)** ____________________

PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them. I acknowledge that I have been offered a copy of Fuller Chiropractic, P.C.'s Notice of Privacy Practices for Protected Health Information, and I have been told that a copy is available at the front desk at any time.

Patient Signature **(X)** ______________________________ Date ____________________

PATIENT PREGNANCY DISCLAIMER (FEMALES ONLY)

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 sure that I am not pregnant
_____ It is possible that I could be pregnant
_____ I am pregnant

Patient Signature **(X)** ______________________________ Date ____________________

NOTE: Female patients should be questioned as to the last date of their menstrual cycle and the 10-day rule should always be applied for protection of the patient and possibly the fetus.

Authorized Provider Representative ______________________ Date ____________________

Witnessing signing of: ☐ Authorization to treat ☐ Insurance assignment ☐ Privacy Notice ☐ Informed Consent ☐ Pregnancy Disclaimer

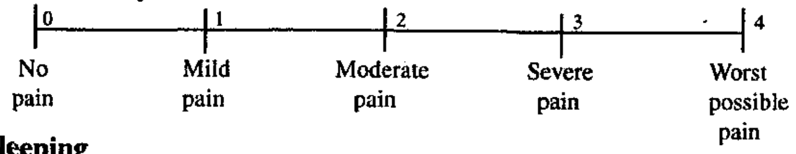
Doctor's notes ____

Functional Rating Index

For use with <u>Neck and/or Back Problems</u> only.

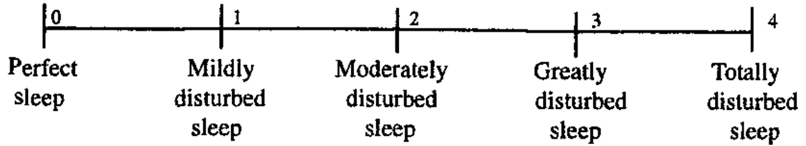
In order to properly assess your condition, we must understand how much your <u>neck and/or back problems</u> have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity



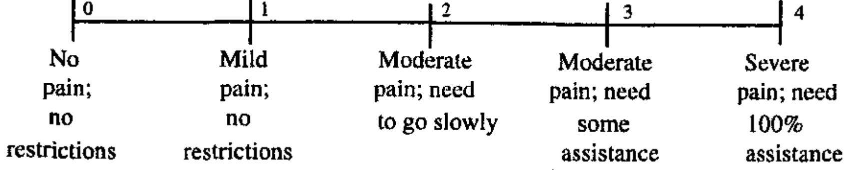
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping



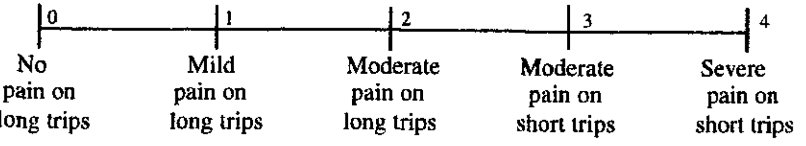
0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)



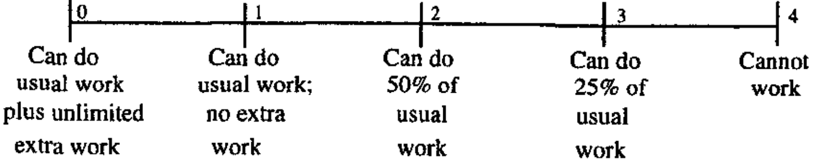
0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)



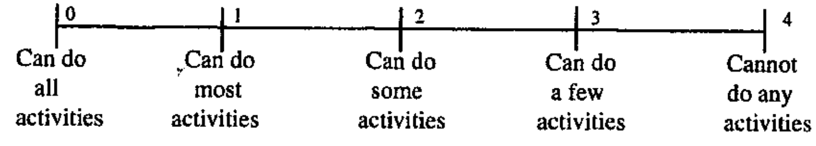
0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work



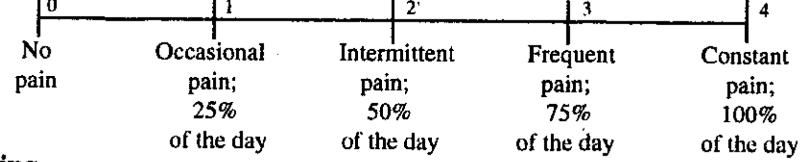
0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation



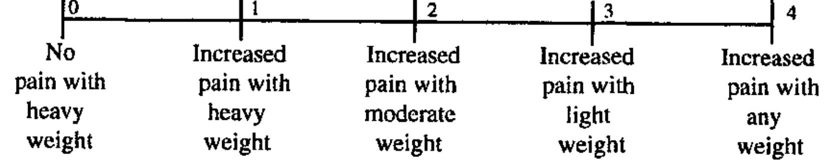
0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain



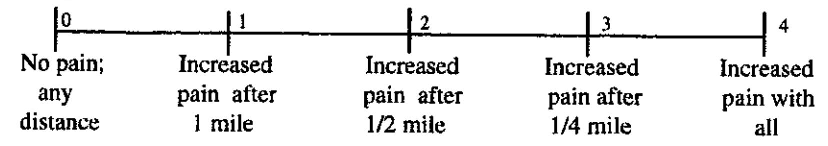
0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting



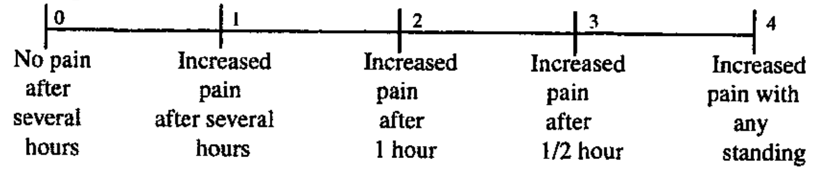
0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking



0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing



0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name ______________________ PRINTED

Total Score ________

______________________ Signature

____________ Date

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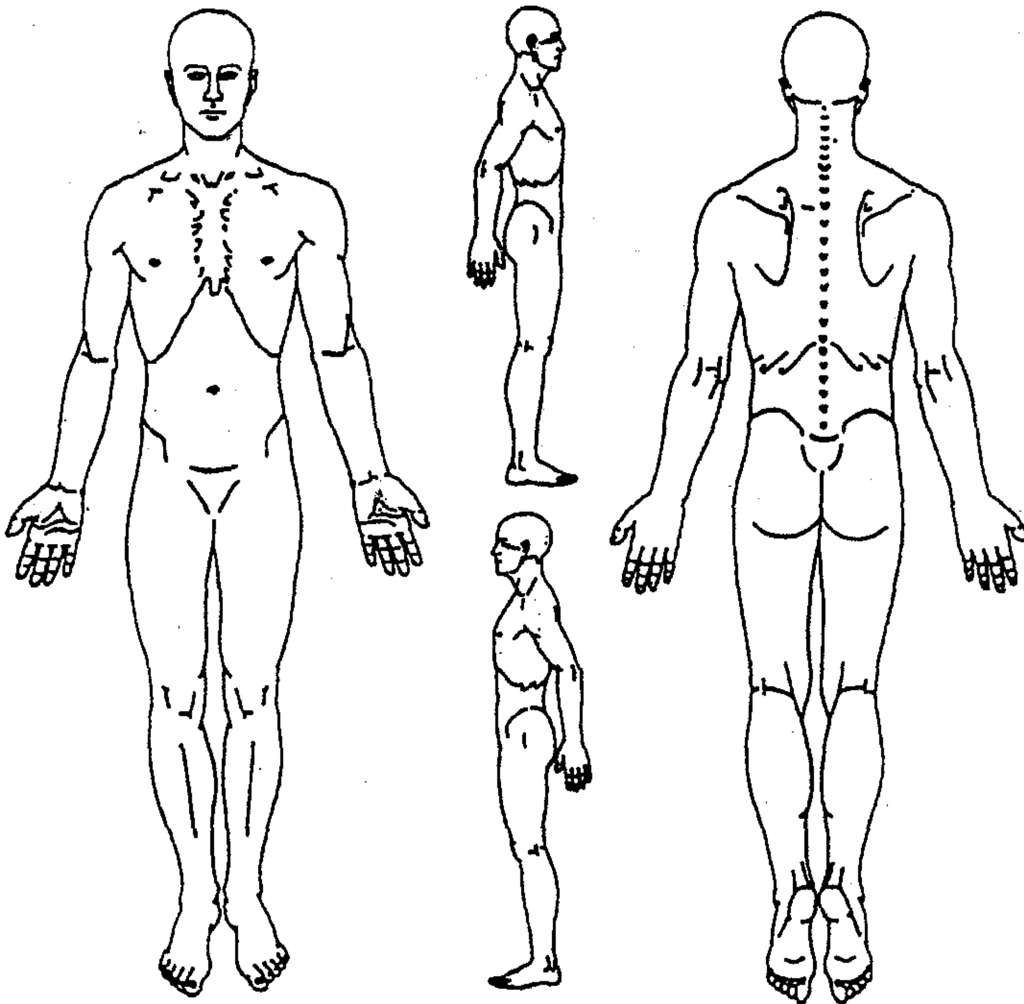
PAIN DIAGRAM

Patient Name: ______________________________ Date: ________________

PLEASE COMPLETE THE FOLLOWING *"PAIN DIAGRAM"* BY USING LETTERS BELOW TO INDICATE ON THE DIAGRAM YOUR AREAS OF PAIN:

A = ACHE	**B = BURN**	**D = DULL PAIN**	**N = NUMBNESS**
P = SHARP PAIN	**S = STIFFNESS**	**T = PINS/NEEDLES/ TINGLING**	**O = OTHER**



Patient's Signature: ______________________________

Review of Systems

Patient Name: ____________________ Signature: __________________ Today's Date:____/____/____

INSTRUCTIONS: Please fill out all of the sections. If none of the conditions apply, select "None."

Constitutional:
- ☐**None**
- ☐Chills
- ☐Daytime Drowsiness
- ☐Fatigue
- ☐Fever
- ☐Night Sweats
- ☐Weight Gain
- ☐Weight Loss

Eyes/Vision:
- ☐**None**
- ☐Blindness
- ☐Blurred Vision
- ☐Cataracts
- ☐Change in Vision
- ☐Double Vision
- ☐Eye Pain
- ☐Field Cuts
- ☐Glaucoma
- ☐Itching *(around the eyes)*
- ☐Photophobia
- ☐Tearing
- ☐Wears Glasses or Contacts

Ears, Nose and Throat:
- ☐**None**
- ☐Bleeding
- ☐Dental Implants
- ☐Dentures
- ☐Difficulty Swallowing
- ☐Discharge
- ☐Dizziness
- ☐Ear Drainage
- ☐Ear Infection*(s)*
- ☐Ear Pain
- ☐Fainting
- ☐Headaches
- ☐Head Injury *(history of)*
- ☐Hearing Loss
- ☐Hoarseness
- ☐Loss of Smell
- ☐Nasal Congestion
- ☐Nose Bleeds
- ☐Post Nasal Drip
- ☐Rhinorrhea *(runny nose)*
- ☐Sinus Infections
- ☐Snoring
- ☐Sore Throats
- ☐Tinnitus *(ringing in the ears)*
- ☐TMJ Disorder

Respiration:
- ☐**None**
- ☐Asthma
- ☐Coughing up blood
- ☐Shortness of Breath
- ☐Sputum Production
- ☐Wheezing

Cardiovascular:
- ☐**None**
- ☐Angina *(chest pain or discomfort)*
- ☐Chest Pain
- ☐Claudication *(leg pain or achiness)*
- ☐Heart Murmur
- ☐Heart Problems
- ☐Orthopnea *(difficulty breathing while lying)*
- ☐Palpitations *(irregular or forceful heart beat)*
- ☐Paroxysmal Nocturnal Dyspnea *(shortness of breath at night)*
- ☐Shortness of Breath
- ☐Swelling of Leg*(s)*
- ☐Ulcers
- ☐Varicose Veins

Gastrointestinal:
- ☐**None**
- ☐Abdominal Pain
- ☐Belching
- ☐Black, Tarry Stools
- ☐Constipation
- ☐Diarrhea
- ☐Difficulty Swallowing
- ☐Heartburn
- ☐Hemorrhoids
- ☐Indigestion
- ☐Jaundice *(yellowing of the skin)*
- ☐Nausea
- ☐Rectal Bleeding
- ☐Abnormal Stool Caliber *(quality)*
- ☐Abnormal Stool Color
- ☐Abnormal Stool Consistency
- ☐Vomiting
- ☐Vomiting Blood

Female:
- ☐**None**
- ☐Birth Control Therapy
- ☐Breast Lumps / Pain
- ☐Burning Urination
- ☐Cramps
- ☐Frequent Urination
- ☐Hormone Therapy
- ☐Irregular Menstruation
- ☐Urine Retention
- ☐Vaginal Bleeding
- ☐Vaginal Discharge

Male:
- ☐**None**
- ☐Burning Urination
- ☐Erectile Dysfunction
- ☐Frequent Urination
- ☐Hesitancy or Dribbling
- ☐Prostate Problems
- ☐Urine Retention

Endocrine:
- ☐**None**
- ☐Cold Intolerance
- ☐Diabetes
- ☐Excessive Appetite
- ☐Excessive Hunger
- ☐Excessive Thirst
- ☐Frequent Urination
- ☐Goiter
- ☐Hair Loss
- ☐Heat Intolerance
- ☐Unusual Hair Growth
- ☐Voice Changes

Skin:
- ☐**None**
- ☐Changes in Nail Texture
- ☐Changes in Skin Color
- *☐Hair Growth*
- ☐Hair Loss
- ☐Hives
- ☐Itching
- ☐Paresthesia (numbness, prickling, or tingling)
- ☐Rash
- ☐History of Skin Disorders
- ☐Skin Lesions or Ulcers
- ☐Varicosities

Nervous System:
- ☐**None**
- ☐Dizziness
- ☐Facial Weakness
- ☐Headaches
- ☐Limb Weakness
- ☐Loss of Consciousness
- ☐Loss of Memory
- ☐Numbness
- ☐Seizures
- ☐Sleep Disturbance
- ☐Slurred Speech
- ☐Stress
- ☐Strokes
- ☐Tremors
- ☐Unsteadiness of Gait

Psychological:
- ☐**None**
- ☐Anhedonia *(inability to experience joy or enjoy life)*
- ☐Anxiety
- ☐Appetite Changes
- ☐Behavioral Change*(s)*
- ☐Bipolar Disorder
- ☐Confusion
- ☐Convulsions
- ☐Depression
- ☐Insomnia
- ☐Memory Loss
- ☐Mood Change*(s)*

Allergy:
- ☐**None**
- ☐Anaphylaxis *(history of)*
- ☐Food Intolerance
- ☐Itching
- ☐Nasal Congestion
- ☐Sneezing

Hematology:
- ☐**None**
- ☐Anemia
- ☐Bleeding
- ☐Blood Clotting
- ☐Blood Transfusion*(s)*
- ☐Bruises easily
- ☐Fatigue
- ☐Lymph Node Swelling