CHIROPRACTIC FIRST CHOICE

Case Number _____

Today's Date _____

CA _____ DC _____

1. Accident / Injury Questionnaire

Title:_____ First:_____ MI:___ Last:_____

Date of accident:_____ Time of accident:_____:_____ am / pm

Type of accident: ❒ Automobile Accident (skip to next section and fill out Auto Accident Questionnaire)

❒ Worker's Compensation Accident/Injury ❒ Slip/Fall Accident ❒ Pedestrian Accident

❒ Other Accident:_____ ❒ Other Injury:_____

What was the cause of your accident / injury:_____

_____

Describe in your own words what happened:_____

_____

_____

2. Immediately After Accident / Injury

Did you lose consciousness? ❒ Yes ❒ No ❒ Unknown

How did you feel (check all that apply):

❒ Confused ❒ Dazed ❒ Dizzy ❒ Nervous ❒ Weak ❒ Other:_____

Where did you immediately develop PAIN (❍) or have lacerations/CUTS (❒) (check all that apply):

PAIN	CUTS		PAIN	CUTS		PAIN	CUTS		PAIN	CUTS		PAIN	CUTS	
❍	❒	Head	❍	❒	Neck	❍	❒	Upper/Mid Back	❍	❒	Lower Back	❍	❒	Pelvis
❍	❒	Abdomen	❍	❒	Shoulders	❍	❒	Chest/Rib Cage	❍	❒	Arms	❍	❒	Elbows
❍	❒	Forearms	❍	❒	Wrists	❍	❒	Hands	❍	❒	Buttocks	❍	❒	Hips
❍	❒	Thighs	❍	❒	Knees	❍	❒	Legs	❍	❒	Ankles	❍	❒	Feet
❍	❒	Other:_____				❍	❒	Other:_____						

Describe any other significant injury:_____

_____

Did you receive emergency care at the accident/injury site? ❒ No ❒ Yes—(please check all that apply):

❒ Bandages ❒ Splints ❒ Brace ❒ Neck Collar ❒ Other:_____

After the accident/injury, where did you go?

❒ Hospital ❒ Home ❒ School ❒ Work ❒ Other:_____

By whom were you driven?

❒ Myself ❒ Friend ❒ Family ❒ Ambulance ❒ Other:_____

3. Hospital Visit After Accident / Injury

When did you go to the hospital? ❒ Immediately ❒ Later That Day ❒ Next Day
❒ Days Later ❒ Other:_____ ❒ **Never** (skip to section 4 on next page)

Hospital name:_____ Examined by doctor:_____

X-rays were taken of what body part/s:

❒ Head ❒ Neck ❒ Upper/Mid Back ❒ Lower Back ❒ Pelvis
❒ Abdomen ❒ Shoulders ❒ Chest/Rib Cage ❒ Arms ❒ Elbows
❒ Forearms ❒ Wrists ❒ Hands ❒ Buttocks ❒ Hips
❒ Thighs ❒ Knees ❒ Legs ❒ Ankles ❒ Feet
❒ Other:_____ ❒ **No x-rays taken**

A CAT scan was performed on what body part/s:

❒ Head ❒ Neck ❒ Upper/Mid Back ❒ Lower Back ❒ Chest/Rib Cage
❒ Abdomen ❒ Other:_____ ❒ **No CAT scan**

A MRI was performed on what body part/s:

❒ Head ❒ Neck ❒ Upper/Mid Back ❒ Lower Back ❒ Chest/Rib Cage
❒ Abdomen ❒ Other:_____ ❒ **No MRI**

What was the diagnosis given at the hospital (describe location on body):

❒ Concussion:_____ ❒ Whiplash:_____
❒ Disc Injury:_____
❒ Dislocation:_____
❒ Fracture:_____
❒ Sprain:_____
❒ Strain:_____
❒ Laceration:_____
❒ Contusions:_____

Describe any additional diagnosis given:_____

_____

What treatment was administered at the hospital?

❒ Oral Medication ❒ Sutures ❒ Splint ❒ Collar ❒ Injection ❒ Ice Packs
❒ Cast ❒ Support ❒ Brace ❒ Surgery ❒ Hot Packs ❒ Bandages
❒ Antiseptics ❒ Other:_____ ❒ **No Treatment**

Upon discharge, whom were you told to see?

❒ General Practitioner ❒ Chiropractor ❒ Neurologist ❒ Physical Therapist
❒ Orthopedist ❒ Internist ❒ General Surgeon ❒ Plastic Surgeon
❒ Other:_____ ❒ **No one**

Upon discharge, what recommendations were made?

❒ Rest ❒ Ice ❒ Heat ❒ Collar ❒ Support ❒ Time off work
❒ Other:_____ ❒ No further care ❒ **No recommendations**

Upon discharge, what medications were prescribed?

❒ Pain ❒ Anti-inflammatory ❒ Antibiotics ❒ Nervousness
❒ Other:_____ ❒ **No medications**

4. Following the Accident / Injury

How much later did additional symptoms develop?

❒ Immediately ❒ Hours ❒ That Evening ❒ Next Morning ❒ Days ❒ Week

❒ Month ❒ Other:_____ ❒ **No other symptoms**

What additional symptoms developed?

	Head	Jaw	Neck	Upper	Mid Back	Low Back	Pelvis	Chest/Ribs	Abdomen	Shoulders	Arms	Elbows	Forearms	Wrists	Hands/Fingers	Buttocks	Hips	Thighs	Knees	Legs	Ankles	Feet/Toes		
(Right)																								
(Left)																								
Pain																								
Burning																								
Numbness																								
Soreness																								
Stiffness																								
Swelling																								
Tingling																								
Weakness																								

Since your accident/injury, have you suffered from:

❒ Blurred Vision ❒ Double Vision ❒ Vision Trouble ❒ Hearing Trouble

❒ Ear Ringing ❒ Chest Pain ❒ Breathing Trouble ❒ Palpitations

❒ Constipation ❒ Diarrhea ❒ Nausea ❒ Vomiting

❒ Frequent Urination ❒ Painful Urination ❒ Incontinence ❒ Anxiety

❒ Depression ❒ Mood Swings ❒ Nervousness ❒ Poor Memory

❒ Tension ❒ Convulsions ❒ Dizziness ❒ Headaches

❒ Fainting ❒ Loss of Balance ❒ Fatigue ❒ Restlessness

❒ Insomnia ❒ Light Sensitivity ❒ Reduced Appetite ❒ Weakness

❒ Weight Gain ❒ Weight Loss ❒ Other:_____

❒ Other:_____ ❒ **No additional symptoms**

Are you restricted in any of the following areas as a result of this accident / injury?

❒ Daily Living ❒ Work/Occupational ❒ Recreational Activities

❒ Other:_____ ❒ **No restrictions**

Have you missed work due to this accident / injury?

❒ Missed no work ❒ Limited work activity ❒ Missed work from:_____to_____

Did you self treat your symptoms?

❒ Ice ❒ Heat ❒ Bed rest ❒ OTC Medication

❒ Other:_____ ❒ **Did not self treat**

Did you seek health care elsewhere?

❒ General Practitioner ❒ Internist ❒ Chiropractor ❒ Neurologist
❒ Orthopedist ❒ General Surgeon ❒ Plastic Surgeon ❒ Psychologist
❒ Other:_____ ❒ Did not seek other health care

Name/s of doctor/s:_____

_____

Diagnosis, treatment and recommendations:_____

_____

_____

Have you had any of the following tests?

❒ CT Scan ❒ MRI ❒ EMG ❒ Other:_____ ❒ No tests

What is the reason for seeking today's consultation?

❒ Persisting Complaints ❒ Worsening of Symptoms ❒ Other:_____

Have you contacted an insurance adjuster or representative regarding this claim?

❒ No ❒ Yes—Company:_____ Claim#:_____

Adjuster:_____ Phone:_____

Have you engaged the services of an attorney?

❒ No ❒ Yes—Attorney:_____

Address:_____ Phone:_____

Have you filed an accident / injury report? ❒ No ❒ Yes

Have you filed for insurance benefits? ❒ No ❒ Yes

Additional information:_____

_____

_____

_____

I certify that the information provided above is accurate and complete to the best of my knowledge.

_____ _____
Patient Name (Please Print) Patient Signature

_____ _____
Date Signed Witness

For office use only:

Patient referred for MRI: ❒ No ❒ Yes—Name:_____

Patient referred to a neurologist: ❒ No ❒ Yes—Name:_____

Referring chiropractor:_____