GET WELL
CHIROPRACTIC

Case Number ____________________

Today's Date ____________________

CA ________ DC ____________

1. Accident / Injury Questionnaire

Title:_______ First:________________________ MI:___ Last:____________________________

Date of accident:____________________________ Time of accident:_______:_________ am / pm

County in which accident took place:____________________________________ State:______________

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:____