Barry Heffron, D.C. P.C. PATIENT CASE HISTORY

Automobile Accident Information (Pg 1of 5)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Email Address: _____ Occupation: _____

Date of Birth: _____ Social Security #: _____-_____-_____ Gender: Male - Female

List any **Allergies**:

□ Animals □ Aspirin □ Bees □ Chocolate □ Dairy □ Dust □ Eggs□ Latex □ Molds □ Penicillin □ Ragweed/Pollen

□ Rubber □ Seasonal Allergies □ Shellfish □ Soaps □ Wheat □ X-Ray Dye □ Other: _____

List any **Surgeries**:

□ Back □ Brain □ Elbow □ Foot □ Hip □ Knee □ Neck □ Neurological □ Shoulder □ Wrist □ Other: _____

List **ALL Past Medical History** conditions:

□ Ankle Pain □ Arm Pain □ Arthritis □ Asthma □ Back Pain □ Broken Bones □ Cancer □ Chest Pain □ Depression

□ Diabetes □ Dizziness □ Elbow Pain □ Epilepsy □ Eye/Vision Problems □ Fainting □ Fatigue □ Foot Pain

□ Genetic Spinal Condition □ Hand Pain □ Headaches □ Hearing Problems □ Hepatitis □ High Blood Pressure

□ Hip Pain □ HIV □ Jaw Pain □ Joint Stiffness □ Knee Pain □ Leg Pain □ Menstrual Problems □ Mid-Back Pain

□ Minor Heart Problem □ Multiple Sclerosis □ Neck Pain □ Neurological Problems □ Pacemaker □ Parkinson's

□ Polio □ Prostate Problems □ Shoulder Pain □ Significant Weight Change □ Spinal Cord Injury □ Sprain/Strain

□ Stroke/Heart Attack □ Other: _____

List Type of **Medications** you are taking:

□ Anxiety □ Muscle Relaxors □ Pain Killers □ Insulin □ Birth control □ Cardiovascular □ Allergy □ Seizure

□ Other: _____

List your **Family History**:

□ Arthritis □ Asthma □ Back Pain □ Cancer □ Depression □ Diabetes □ Epilepsy □ Genetic Spinal Condition

□ High Blood Pressure □ Heart Problems □ Multiple Sclerosis □ Neurological Problems □ Parkinson's □ Polio

□ Prostate Problems □ Stroke/Heart Attack □ Other: _____

Date of last physical examination: _____ Do you smoke? □ No □Yes

Do you drink alcohol? □ No □Yes - how much per day? _____

Do you drink caffeine? □ No □Yes - how much per day? _____

Do you exercise? □ No □Yes (what forms and how often): _____

Automobile Accident Information (Pg 2 of 5)

Auto Accident Info:

Describe your accident in detail _____

_____

Date and Time of accident: _____

Were you stopped? _____ Speed MPH: You _____ Them_____

Road Conditions: Rain Dry Icy Snow

Visibility: Excellent Fair Good Poor

Were you wearing seat belts? _____ Were you looking straight ahead? _____

Headrest Position: Low Middle High

Were you the driver? _____ Passenger sitting in front or rear? _____

Type of car Sedan or SUV – Yours _____ Theirs _____

Were you gripping the steering wheel? _____ Did you tighten up? _____

Were you aware the collision was to take place? _____ Unconscious? _____

After the accident:

Did you feel tightness in the: arms chest neck? _____ (circle where)

Did you feel your neck move: backwards forwards sideways? (circle how)

Did you feel your upper and lower body move: backwards forwards sideways? (circle how)

Did any part of your body make contact with the car, where? _____

Were you bruised, where? _____

Were paramedics called? _____ Were you taken to the hospital? _____

Which Hospital? _____ Treatment?_____

Recommendations _____

Were you able to drive home? _____ Did you go to work? _____

Did you go to a doctor or clinic? _____ How many days after the accident? _____

What was done? _____ What doctors have you seen? _____

Their names and specialty? _____

Have they helped? _____ Have you been released from care? _____

Automobile Accident Information (Pg 3 of 5)

Activities of Daily Living:

Has the injury from this accident affected your ability to perform your job? No / Yes

Describe your normal work routine:

_____

Are you having difficulties at Home, Socially, Sports?_____

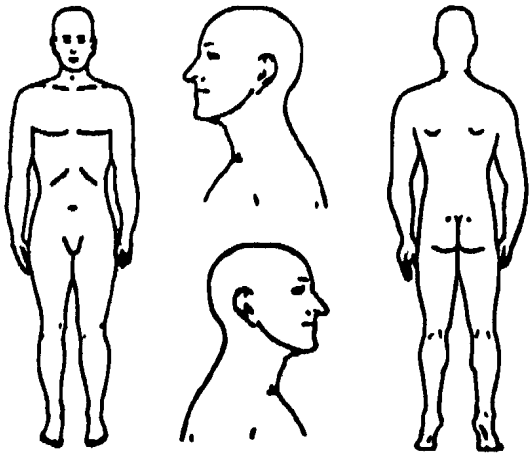
Have you taken time off from work? _____ How many days? _____

List implants or prostheses _____

Please list previous accident history _____

_____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

- ☐ Become pain free
- ☐ Explanation of my condition
- ☐ Learn how to care for my condition
- ☐ Reduce symptoms
- ☐ Resume normal activity level

Automobile Accident Information (Pg 4 of 5)

What is your One major complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

What is your SECOND complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

Automobile Accident Information (Pg 5 of 5)

What is your Third complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

Note: Payments for all services are your responsibility. If you intend on using any form of insurance, assignment of benefits, an attorney, settlement, or other means of payment, we will assist you in filing for services rendered. **But,** any outstanding balance for all services rendered, and not paid, will be your responsibility. Signing below acknowledges this responsibility.

Patient's / Guardian's Signature_____Date_____

_____**Office Use Below**_____