WELCOME

Thank you for presenting to our office today.
Evaluation Intake Form for Wharfside Chiropractic Center

Today's Date: _____

Patient Name: _____ Male ___ Female ___
LAST FIRST MI
What do you prefer to be called? _____

Birthdate: _____/_____/_____ Age: _____ SS#: _____

Mailing Address: _____
_____

Home Phone: _____ Work Phone: _____ Cell: _____
Email Address: _____
Referred by: _____
Employer: _____
Employer's Address: _____
Occupation: _____
Status: Minor___ Single ___ Married _____ Divorced ___ Separated __ Widowed ____
Spouses Name: _____Do you have children? Yes __ No __ How many? __

REASON FOR VISIT:
The reason for today's visit is a result (Please circle only one): Work, sports, auto, other trauma, or chronic condition.
Explain what happened: _____
IF ACCIDENT COMPLETE a – y.

a. Date and time of accident: _____
b. B. Were you the Driver ___ Front Passenger ___ Rear Passenger ____
c. If a traffic violation was issued, to whom was it issued? _____
d. Number of people in accident vehicle? _____
e. Did police come to the accident site? _____
f. Was a police report filed? _____
g. Were there any witnesses? _____
h. Were you wearing seat belts? _____ Safety shoulder harness? _____
i. Was the vehicle equipped with airbags? _____ Did they inflate? _____
j. In relation to the base of your skull, where was the headrest? Above ___
   Below____ Base of skull _____
k. What impacted with your vehicle? _____
l. Did you, or any part of your body, impact with anything in your vehicle? _____
   _____
m. Make and model of the vehicle you were occupying? _____

Has your condition changed since your injury/accident? Yes ___ No ____
Please describe _____

Do you feel your condition is getting worse? Yes ____ No ___

Have you had this or similar conditions in the past? Yes ___ No ___

Have you ever had any surgeries or been told you have a (any) serious or significant medical condition? If yes, please list: _____
_____
_____

Have you retained an attorney? Yes__ No ___ If yes, whom: _____

Are you presently taking any vitamins or supplements? Yes ___ No ___
If yes, please list. _____

FOR WOMEN: Are you taking Birth Control? Yes ___ No ____
Is there any way you might be pregnant? Yes ___ No ___ Possibly ___
Are you Nursing? Yes __ No ____

ACCOUNT INFORMATION:
Person ultimately responsible for account? _____
Relation: _____ Billing Address _____
_____
SS#: _____
Payment Method: Cash _____ Check ____ Credit card ____ Other _____
If using a third party (Insurance, etc) for any portion of your services with our office please initial that you hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company or any other third party utilized for assignment of benefits. Initial _____

ADDITIONAL INSURNCE
2^{ND} Insurance Source
Type of Insurance _____ Co. Name: _____ Insured's Name: _____
Address of Insurance:_____
Phone #: _____ Policy #: _____

Thank you for taking the time to complete our questionnaire form to assist our Doctor with your Consultation today.

_____
Patient Signature

n. Name of the location/area on which you were traveling? _____

_____

o. In which direction were you heading? N__ S___ E____ W___
p. What was the approx. speed of your vehicle _____
q. If known, what was the speed limit of the road you were traveling? _____
r. Did the impact to your vehicle come from the: Front ____ Rear ____ Right Side___ Left Side ____ Other _____
s. During impact, were you facing: Forward ____ Right ____ Left____ Unsure __
t. Were you aware_____ or surprised _____ by the impact?
u. If accident vehicle made impact with another vehicle… Make of other vehicle if known: _____
v. Direction other vehicle was headed? N____ S____ E____ W____
w. Speed of other vehicle (aprox) if known? _____
x. In any other words that might be helpful, please describe the accident or other relevant points of impact: _____

_____

y. Did the accident render you unconscious? Y____ No____ Not sure _____

Please describe how you were feeling immediately prior to accident: _____

_____

Please describe how you felt immediately after the accident: _____

_____

Have you gone to a Hospital or seen any other doctor? Yes ___ No ___
When did you go? Just after accident ___ Next day ____ 2 days plus _____
How did you get there? Ambulance ___ Someone else ___ Self _____
Name of Hospital and/or attending physician: _____
Was he a D.C. ____ M.D. ____ D.O. _____ D.D.S. ___ Other: ____
Describe any treatment you have received: _____

_____

Were X-rays or other pictures(MRI, CT, etc) taken? Yes ___ No ___ If yes, are you aware of the Results? _____
Any medication been prescribed? _____ Are you taking any medication now? Is so, please list.

_____

Were you working prior to accident? Yes ___ No ____
If you were working, have you returned? Yes ___ No ___

Please indicate any symptoms that you feel might be a result of this accident:

Dizziness __ *Difficulty Sleeping*___ *Jaw Problems* __ *Nausea* ___ *Memory Loss* ___ *Irritability* ___
Arms/Shoulder Pain ___ *Back pain* ____ *Headache* ___ *Fatigue* ___ *Numb Hands/Fingers* ___
Lower Back Pain ___ *Blurred Vision* ___ *Tension* ___ *Chest Pain* ___ *Back Stiffness* ___ *Buzzing in ear* ___
Neck Pain ___ *Shortness of Breath* ___ *Leg pain* ___ *Ears Ringing* ___ *Neck Stiffness* ___ *Upset Stomach* ___
Numb Feet/Toes ___ *Other* _____

Please list any and all activities that you feel have become painful or uncomfortable to perform (i.e.: lifting, bending, sitting, driving, etc..): _____

_____