NEWMAN CHIROPRACTIC CENTER
527 Shady Avenue
Pittsburgh, Pennsylvania 15206

Name _____ Date _____

Address _____
Street City State Zip

Home Phone ( ) _____ Work Phone ( ) _____

Birthdate _____ Social Security #_____/_____/_____ Marital Status _____

Spouse's Name _____ Occupation _____

Employer _____ Do you have Health Insurance _____

Company Name _____ Policy Number _____ Group # _____

Please explain in detail how your accident happened _____

_____

_____

_____

_____

_____

You were heading ___North ___East ___South ___West on _____

Other vehicle was headed ___North ___East ___South ___West on _____

Were you knocked unconscious? ☐ Yes ☐ No

If so, for how long? _____

You were struck from ___behind ___front ___left side ___right side

You were ___ driver ___passenger ___front seat ___back seat ___using seat belts

Where did you feel pain immediately after the accident? _____

_____

Where did you go after the accident? ___hospital ___by ambulance ___self ___work home ___school

What treatment was provided? _____

Were you x-rayed? ☐ Yes ☐ No

Was any other doctor consulted after your accident? ☐ Yes ☐ No

If so, what was the doctor's name? _____

What was the diagnosis? _____

What treatment was provided? _____

How long did you treat with the doctor? _____

Have you ever had same or similar complaints? ☐ Yes ☐ No

If yes, when _____

If so, what were the complaints? _____

Since this injury, are your symptoms ___improving ___getting worse ___same

Are your activities restricted as a result of this accident? ☐ Yes ☐ No

Is there any chance that you may be pregnant? ☐ Yes ☐ No

Number of prior pregnancies? _____

Your level of education _____

Recreational activities or hobbies _____

Do you exercise? ☐ Yes ☐ No

If yes, please note type _____

Nature of your diet _____

Have you completed an advanced directive or living will? ☐ Yes ☐ No

If so, please furnish a copy to be maintained in your file.

Your automobile insurance company _____

Your insurance agency _____ Claim Number _____

Do you have an attorney representing you? ☐ Yes ☐ No

If yes, please note name, address and telephone number _____

_____

Who owned the car that you were in when hit? _____

Was anyone else injured? ☐ Yes ☐ No

If yes, who? _____

Was a police report made? ☐ Yes ☐ No

Did you report the accident to the appropriate insurance company? ☐ Yes ☐ No

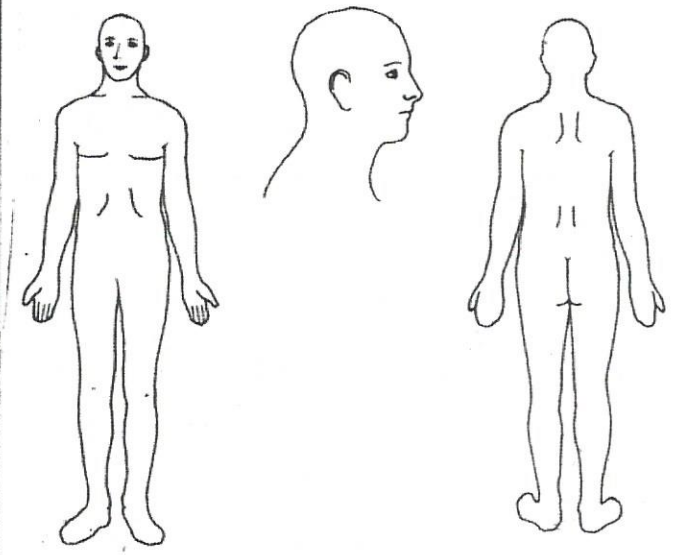
If yes, what company? _____

Date of accident _____ Date you reported accident _____

Did you miss work? ☐ Yes ☐ No

If yes, please give dates _____

Please mark your areas of pain on the figures below.



Please mark the intensity of your pain today.

0 - NO PAIN

10 - INTENSE PAIN

Example Neck

O 1 2 3 ④ 5 6 7 8 9 10

1. _____

O 1 2 3 4 5 6 7 8 9 10

2. _____

O 1 2 3 4 5 6 7 8 9 10

3. _____

O 1 2 3 4 5 6 7 8 9 10

X _____

Patient's Signature Date

DO NOT WRITE BELOW THIS LINE

_____

_____

_____

_____

_____

Patient accepted? ☐ Yes ☐ No Doctor's Signature _____

CONFIDENTIAL PATIENT CASE HISTORY

Please list any past and/or present surgeries or procedures you've had performed (please date): _____

_____

_____

☐ I have never had any operations/surgeries.

Are you presently taking any medication-prescription or over-the-counter? ☐ Yes ☐ No If yes, what drugs? _____

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Other	
Mother	☐	☐	☐	☐	☐	_____
Father	☐	☐	☐	☐	☐	_____
Brother, # of:_____	☐	☐	☐	☐	☐	_____
Sister, # of:_____	☐	☐	☐	☐	☐	_____

HABITS

☐ Smoking Packs/Day: _____

☐ Drinking Alcohol: _____

☐ Caffeine Cups/Day: _____

☐ Substance Abuse Type: _____

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD:

☐ Alcoholism
☐ Allergies
☐ Anemia
☐ Appendicitis
☐ Arteriosclerosis
☐ Arthritis
☐ Asthma
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Eczema
☐ Emphysema
☐ Epilepsy
☐ Goiter
☐ Heart Disease
☐ HIV/AIDS
☐ Kidney
☐ Miscarriage
☐ Multiple Sclerosis
☐ Pneumonia
☐ Rheumatic Fever
☐ Ulcers
☐ Venereal Disease
☐ Other:_____

RESPIRATORY

☐ Chest Pain
☐ Chronic Cough
☐ Difficulty Breathing
☐ Spitting Blood
☐ Spitting Phlegm

CARDIO-VASCULAR

☐ High Blood Pressure
☐ Low Blood Pressure
☐ Pain Over Heart
☐ Poor Circulation
☐ Previous Heart Trouble
☐ Rapid Heart
☐ Slow Heart
☐ Strokes
☐ Swelling in Ankles
☐ Varicose Veins

FOR WOMEN ONLY

☐ Cramps or Backaches
☐ Excessive Flow
☐ Hot Flashes
☐ Irregular Cycle
☐ Painful Periods
☐ Lump in Breast
☐ Pregnant at this Time?
☐ Have you had a Mammogram?
Last Pap Smear Date_____

Have you ever had any mental or emotional disorders? ☐ Yes ☐ No ☐ When? _____

Have others in your family had such disorders? ☐ Yes ☐ No ☐ When? _____

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home):

Name _____ Relationship _____ Tele # _____

PATIENT'S/GUARDIAN

PRINT NAME _____ DATE _____

SIGNATURE X _____