First Name: ____________________________ **M.I.**:____ **Last Name**: ____

What Do You Prefer To Be Called: _______________ **DOB**: _______________ **Age**: ____________________________

Address: ____

City: ____________________________ **State**: _______________ **Zip Code**: ________________

SS #: ____________________________ **Sex: M / F Email**: ____

Home #: ____________________ **Cell #**: _____________________ **Other #**: ________________

Single \ Married \ Divorced \ Widow Spouse/ Partner Name: ____

Emergency Contact: __________________ **Relationship**: _____________ **T**: _________________________________

AUTO INSURANCE INFORMATION:

Name of Insurance Company: ____

Address: ____

City: ________________________________ State: ________ Zip Code: ____________________

Policy #:: ______________________________ Claim #: ___________________________________

Adjuster's Name: ___________________________________ T: ______________________ EXT _______

ATTORNEY INFORMATION:

Law Firm: ____ Phone: ______________________________

Attorney's Name: _________________________________ Paralegal: ____________________________

Address: ____

City: ________________________________ State: ________ Zip Code: _____________________

– Please hand the front desk all of your insurance cards –
– They will copy them & return back to you –

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorize Legacy Clinic of Chiropractic to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

_______________________________ _____________ ______________________________
Signature Date Parent (if patient is a minor)

1. **Date of Accident**: _____/_______/_______ **Time of Day**: _______:_________________ am / pm

2. **Number of people in your vehicle**: ________ 3. **In dollars, please enter the estimated damage to your vehicle** $____________

4. **What road were you on?** ______________________________________

5. **What direction were you traveling in?**

N	NE	W	E	SW	S	SE

6. **What city and state were you in?** ____

7. Please choose the primary type of impact:

Vehicle was rear ended	Vehicle hit another vehicle from behind	Vehicle was hit on the passenger's side

8. What did your vehicle do after the accident?

Hit a guardrail	Hit a tree	Rolled over	Was run off the road	Other:

9. Where were you sitting in this vehicle?

Driver	Rear left passenger	Rear passenger	Front passenger	Rear left passenger

10. Did you know the accident was coming?

Was unaware of the impending collision	aware the impending collision and braced his/herself	aware of the collision and relaxed

Other: ____

11. What is the type of vehicle you were in?

Subcompact car	Compact car	Mid-size car	Full-sized car	Truck
SUV	Minivan	Van	Larger than 1 ton vehicle	

12. At the time of the impact, your vehicle was:

Slowing down	Gaining speed	Stopped	Moving at a steady speed

13. At the impact the other vehicle was:

Slowing down	Gaining speed	Stopped	Moving at a steady speed

14. During and after the crash, what happened to your vehicle?

kept going straight	Kept going straight hitting a car in front	Was hit by another car
Spun around	Spun around and hit a stationary object	

15. Did you lose consciousness during the accident? ☐ Yes ☐ No

16. How was your head positioned during the accident?

Facing forward	Turned to the left	Turned to the right	Facing upward	Facing downward
Facing to the right and upward	Facing to the right and downward	Facing left and upward	Facing left and downward	

16. How was your torso positioned during the accident?

positioned forward	Turned to the left	Turned to the right	extended	flexed
Flexed with right rotation	Extended with right rotation	Flexed with left rotation	Extended with left rotation	

17. How were your hands positioned during the accident?

Left hand on steering wheel	Right hand on steering wheel	Both hands on steering wheel	Left hand on dashboard	Right hand on dashboard
Both hands on dashboard	Hand on the seat in front	Hans resting along side	Hands on ceiling	

18. Did your head, face, shoulders, neck, chest, hips, knees, feet hit any of the following? (Please write body part in box)

windshield	Steering wheel	Side door	Dashboard	Ceiling
Car frame	Another passenger	Seat	Side window	

19. What kind of head rests were in your vehicle?

Moveable fixed head restraints	Fixed, non movable head restraints	No head restraints

20. Did you have your seat belt on?

Was wearing a shoulder strap seat belt	Was wearing a lap belt seat belt	Was in a baby car seat
Was not wearing her seatbelt	Cannot remember if she had a seat belt on	Was in a booster seat

21. What was damaged in your vehicle?

Windshield	Steering wheel	Dashboard	Seat frame
Side window	Rear window	Mirror	Knee bolster
Rear bumper	Trunk	Completely totaled	Front left door
Front right door	Back left door	Back right door	none

22. Did you go to the hospital? ☐ Yes ☐ No

23. Please choose the locations of your problems:

Headaches	Jaw	Neck	Upper back	Shoulder
Arm	Elbow	Wrist	Hand	Mid back
Low back	Hip	Legs	Knee	Ankle
foot				

Symptoms other than above: ____

24. Were you hospitalized overnight? ☐ Yes ☐ No

25. Were you prescribed anything? ☐ Yes ☐ No

If yes what? ______________________________

26. Which x-rays were taken?

Skull	Neck	Midback	Lowerback	Foot	arm
Pelvis	Hips	Leg	Knee	Shoulder	No x-rays

27. Was an MRI performed? □ Yes □ No

Skull	Neck	Midback	Lowerback	Foot	arm
Pelvis	Hips	Leg	Knee	Shoulder	No MRI

28. Did you have any physical complaints <u>BEFORE</u> the accident?: ☐ Yes ☐ No

If yes, please describe in detail: ____

29. Do you have any previous illnesses which relate to this case?: ☐ Yes ☐ No

If yes, please describe: ____

30. Have you ever been involved in an accident before?: ☐ Yes ☐ No

If yes, please describe, including date(s) and type(s) of accidents, as well as injury/injuries received:

____

31. Have you been treated by another doctor since the accident?: ☐ Yes ☐ No

If yes, please list doctor's name and address: ____

____

What type of treatment did you receive? ____

32. Have you lost time from work as a result of this accident?: ☐ Yes ☐ No

If yes, please complete the following questions:

a. Last Day Worked: ____

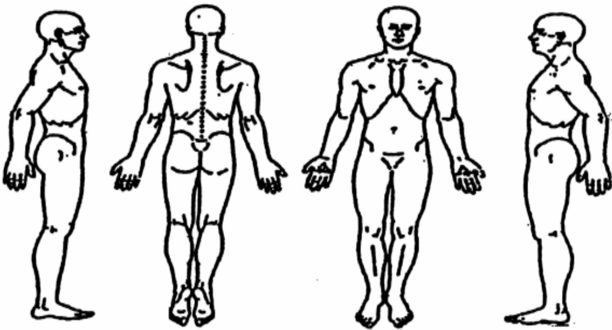
b. Type of Employment: ____

22. Do you notice any activity restrictions as a result of this injury?: ☐ Yes ☐ No

If yes, please describe, in detail: ____

____

Indicate on the drawings below where you have pain/symptoms:



How often do you experience your symptoms?

☐ Constantly (76-100% of the time) ☐ Frequently (51-75% of the time)
☐ Occasionally (26-50% of the time) ☐ Intermittently (1-25% of the time)

How would you describe the type of pain?

☐ Sharp ☐ Numb ☐ Dull ☐ Tingly ☐ Diffuse ☐ Achy
☐ Burning ☐ Shooting ☐ Stiff ☐ Sharp w/ Motion ☐ Shooting w/ Motion
☐ Stabbing w/ Motion ☐ Electric like ☐ Other: ______________________

How are your symptoms changing with time?

☐ Getting Worse ☐ Staying the Same ☐ Getting Better

Using a scale from 0 – 10 (10 being the worst), how would you rate your symptom? (Each symptom)

0 1 2 3 4 5 6 7 8 9 10 (Please Circle)

What aggravates your symptoms? ______________________________________

What alleviates your symptoms? ______________________________________

What is your: **Height**: ____________ **Weight**: __________

How would you rate your overall health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

What type of exercise do you do?

☐ Strenuous ☐ Moderate ☐ Light ☐ None

SOCIAL HISTORY

1. **Smoking**: → **How often?** ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

2. **Alcoholic Beverage Consumption:** → ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

4. **Extracurricular Activities**:____

5. **Impact of Current Condition on Work Capacity:** ☐ No Effect ☐ Painful ☐ Limits ☐ Unable to work

What extracurricular activities do you participate in? ____

Indicate if you have any immediate family members with any of the following:

☐Rheumatoid Arthritis ☐ Diabetes ☐ Lupus
☐ Cancer ☐ ALS ☐ Heart Problems

List all prescription medications you are currently taking: ____
____

List all of the Supplements/Vitamins you are currently taking: _______________________________________
____

List all surgical procedures you have had: ____
____

Have you ever been hospitalized? ☐ No ☐ Yes
If yes, why____

Have you ever significant past trauma? ☐ No ☐ Yes

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
☐	☐ Headaches	☐	☐ High Blood Pressure	☐	☐ Diabetes
☐	☐ Neck Pain	☐	☐ Heart Attack	☐	☐ Excessive Thirst
☐	☐ Upper Back Pain	☐	☐ Chest Pains	☐	☐ Frequent Urination
☐	☐ Mid Back Pain	☐	☐ Stroke	☐	☐ Smoking/Tobacco Use
☐	☐ Low Back Pain	☐	☐ Angina	☐	☐ Drug/Alcohol Dependence
☐	☐ Shoulder Pain	☐	☐ Kidney Stones	☐	☐ Allergies
☐	☐ Elbow/Upper Arm Pain	☐	☐ Kidney Disorders	☐	☐ Depression
☐	☐ Wrist Pain	☐	☐ Bladder Infection	☐	☐ Systemic Lupus
☐	☐ Hand Pain	☐	☐ Painful Urination	☐	☐ Epilepsy
☐	☐ Hip Pain	☐	☐ Loss of Bladder Control	☐	☐ Dermatitis/Eczema/Rash
☐	☐ Upper Leg Pain	☐	☐ Prostate Problems	☐	☐ HIV/AIDS
☐	☐ Knee Pain	☐	☐ Abnormal Weight Gain/Loss		
☐	☐ Ankle/Foot Pain				
		☐	☐ Loss of Appetite	**For Females Only**	
☐	☐ Jaw Pain	☐	☐ Abdominal Pain	☐	☐ Birth Control Pills
☐	☐ Joint Pain/Stiffness	☐	☐ Ulcer	☐	☐ Hormonal Replacement
☐	☐ Arthritis	☐	☐ Hepatitis	☐	☐ Pregnancy
☐	☐ Rheumatoid Arthritis	☐	☐ Liver/Gall Bladder Disorder		
☐	☐ Cancer	☐	☐ General Fatigue		
☐	☐ Tumor	☐	☐ Muscular Incoordination		
☐	☐ Asthma	☐	☐ Visual Disturbances		
☐	☐ Chronic Sinusitis	☐	☐ Dizziness		
☐	☐ Other:____________________________				

I affirm that the information I have given is correct to the best of my knowledge. The information I have provided will remain confidential, and I understand that it is my responsibility to inform this office of any changes in my medical status

PRINT PATIENT NAME	SIGNATURE	DATE

INFORMED CONSENT

I understand and am informed that, as in all health care, in the practice of chiropractic there is a small inherent risk of injury which includes but is not limited to, muscle strains, sprains, fractures, dislocation, intervertebral disc injury, and cardiovascular accident. I understand that Dr. John C. Theeck will not be able to anticipate all potential complications, but will rely on clinical expertise and judgment to determine the correct course of treatment, which will be in my best interests considering all known facts. I understand that results are not guaranteed and that I have the opportunity to discuss the purposes and risks associated with all recommended evaluation and treatment procedures at any time.

I have read and understand the preceding statements and herby consent to voluntarily participate in orthopedic, neurologic and physical performance testing, as well as manipulative, and exercise/rehabilitation therapies as deemed appropriate by Dr. John C. Theeck. If at any time, I have further questions or decide not to continue to consent in treatment, I understand I have that right and it is my duty to notify my doctor.

PRINT PATIENT NAME	SIGNATURE	DATE

If patient is a minor:

PRINT PARENT/GUARDIAN NAME	SIGNATURE	DATE

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient Name (please print)	Date
Parent, Guardian or Patient's legal representative	Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.
List below the names and relationship of people to whom you authorize the Practice to release PHI.

Name	Relationship
Name	Relationship