

If your injuries could be due to an AUTO ACCIDENT, please fill out this page.

Accident Patient History

Date of Accident _____ Time _____

Were you: Driver Passenger Front Seat Back Seat

Were you wearing a Seat Belt? Y ___ N ___ Shoulder Harness? Y ___ N ___

Description of Accident

Were you struck: From Behind In Front Right Front Right Middle Right Rear
 Left Front Left Middle Left Rear

Were you: Moving Stopped Turning Right Turning Left

Approximate speed of automobiles at time of impact _____

Did you see the accident coming? Y ___ N ___

Which way were you looking at the time of impact? _____

Upon impact which way was your body thrown? Forward Backward Right Left

Did you hit your head on anything? Y ___ N ___ What? _____

Lose consciousness? Y ___ N ___ How Long? _____

Amount of damage to vehicle? _____

Type of vehicle? _____

Police report filed? Y ___ N ___ What county? _____

Citation issued? Y ___ N ___ To whom? _____

When did the pain begin? _____

Since Motor vehicle accident- pain is: Less Same Worse

Transported to hospital? Y ___ N ___ Hospital Name: _____

X-rays taken? Y ___ N ___

Instructions from ER Doctor _____

Have you seen another Dr. since Motor Vehicle Accident? Y ___ N ___

Dr. Name _____

What treatment did you receive? _____

Welcome to Tallant Chiropractic

Please fill out our Health Record as completely and accurate as possible. If you have any questions, please don't hesitate to ask. It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being with Chiropractic care.

About this Patient

First Name

-

Last Name

-

Birthday

-

Cell Phone

-

Email

-

Gender

Male Female

Other

Marital Status

- Minor
- Single
- Married
- Divorced
- Widowed
- Separated
- Domestic Partnership

Social Security #

-

Referred By

-

Street Address

-

City

-

State/Province

-

Zip Code

-

About the Spouse

First Name

-

Last Name

-

Spouse's Cell Phone

-

Employer Information

Employer

-

Work Address

-

Work City

-

Work State

-

Work Zip

-

Work Phone

-

Type of Work

-

Reason for this Visit

Is the purpose of this appointment related to:

- Job**
- Fall**
- Other**
- Sports**
- Chronic Discomfort**
- Auto**
- Home Injury**

Please explain.

-

When did this condition begin?

-

Has this condition

- Gotten worse**
- Stayed Constant**
- Comes and goes**

If job related, have you made a report of your accident to your employer?

- Yes**
- No**

Has this condition occurred before?

- Yes**
- No**

Does this condition interfere with

- Work**
- Sleep**
- Daily Routine**
- Other activities**

Explain

-

Have you seen other doctors for this condition?

- No**
- Yes**

Doctor's Name (s)

-

Type of Treatment

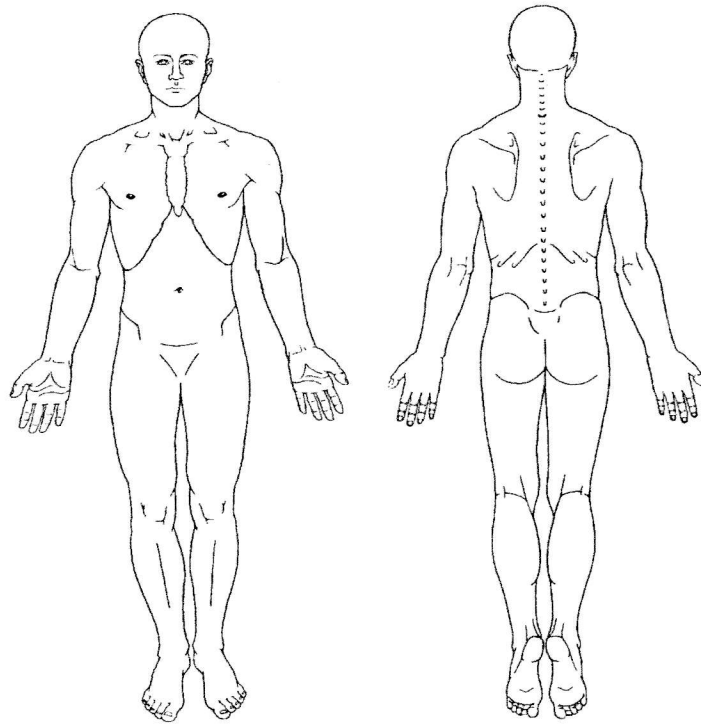
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Results

-

Place an X on the image below, where you feel pain, numbness or tingling:

Mark your Pain Point



Experience with Chiropractic

Have you been adjusted by a chiropractor before?

Yes No

Doctor's Name

-

Approximate date of last visit?

-

Reason for those visits?

-

Awareness of Chiropractic Principles

Were you aware that...

Doctors of Chiropractic work with the nervous system?

Yes No

The nervous system controls all bodily functions and systems?

Yes No

Chiropractic is the largest natural healing profession in the world?

Yes No

If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?

Yes No

Goals for my Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of their pain, and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care: Symptomatic relief of pain or discomfort

Yes

Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms

Yes

Comprehensive Care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

Yes

Health Habits & Conditions

Medications I Now Take:

Nerve Pills

Blood Pressure Medicine

Blood Thinners

Pain Killers (including Aspirins)

Insulin

Tranquilizers

Muscle Relaxers

Stimulants

Do you smoke?

Yes No

Do you drink alcohol?

Yes No

Do you drink coffee?

Yes No

Do you exercise regularly?

Daily Moderately No

Health Conditions:

Severe or Frequent Headaches

Cancer

Pain Between the Shoulders

Lower Back Problems

Heart Attack/Stroke

Congenital Heart Defect

Psychiatric Problems

Asthma

Venereal Disease

Tuberculosis

Anemia

Sinus Problems

Loss of Sleep

Frequent Neck Pain

Digestive Problems

Thyroid Problems

Heart Surgery/Pacemaker

Difficulty Breathing

Arthritis

HIV/AIDS

Shingles

Dizziness

Hepatitis

Numbness in Arms/Legs/Hands

Ulcers/Colitis

Kidney Problems

High/Low Blood Pressure

Rheumatic Fever

Alcohol/Drug Abuse

Diabetes

Chemotherapy

Are you pregnant?

Yes No

Who should receive bills for payment on your account?

Patient

Workers Comp

Auto Insurance

Spouse

Medicare

Parent

Personal Health Insurance

Emergency Contact

First Name

-

Last Name

-

Relationship

-

Work Phone

-

Home Phone

-

My Health Insurance

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will provide any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt.

Insurance Company

-

Policy #

-

Group #

-

Address

-

Phone Number

-

ABOUT THE INSURED PERSON

First Name

-

Last Name

-

Social Security #

-

Date of Birth

-

Relation

-

Nutrition and self-care are just two of the components in obtaining optimal wellness.

Please let us know what you are currently doing for your health.

Things I do currently to support my health include:

- | | | |
|---|--|--|
| <input type="checkbox"/> Drink plenty of water | <input type="checkbox"/> Exercise regularly | <input type="checkbox"/> Get plenty of rest |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Pray/Meditate | <input type="checkbox"/> Yoga/Pilates/Aerobics |
| <input type="checkbox"/> Alcohol in moderation | <input type="checkbox"/> Homeopathic remedies | <input type="checkbox"/> Maintain positive attitude |
| <input type="checkbox"/> Self-improvement books | <input type="checkbox"/> Eat organically grown foods | <input type="checkbox"/> Vitamins, minerals or herbs |
| <input type="checkbox"/> Maintain the proper weight | <input type="checkbox"/> Receive regular massages | <input type="checkbox"/> Counseling/Therapy |
| <input type="checkbox"/> Orthotics/Heel Lefts | <input type="checkbox"/> Use a cervical pillow | <input type="checkbox"/> Attend religious services |
| <input type="checkbox"/> Annual physical examinations | | |

Please list any vitamin supplements you are currently taking

-

Initial Consultation Form

Primary Complaint (s):

-

Overall frequency of complaint (choose one)

- Constant - 100% of the time** **Frequent - 75%** **Intermittent - 50%**
 Occasional - 25%

Overall intensity of complaint (choose one)

- Minimal (An annoyance but has no effect on activity)**
 Slight (Tolerable with some impairment to activity)
 Moderate (Tolerable with marked impairment of activity)
 Severe (Intolerable and cannot perform any activities)

Is this problem affecting any other area of your body? If yes, please explain:

-

Does it interfere with your normal daily activities (Family, recreation, sports)?

-

Does your symptoms increase while performing your normal work duties?

- Yes** **No**

What aggravates the problem?

-

What relieves the problem?

-

If this problem went without being taken care of, how do you think it would affect you?

-

Missed Appointments

We strive to provide you with the utmost professionalism and excellence of service. Our commitment to your well-being and health is something we take seriously.

We care about you and realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need and to the actions we recommend to you.

- Your faithfulness to the recommended number of adjustments is key to ensuring optimum results.
- With the exception of emergencies, it is vital that you keep all your appointments. Reminder cards are provided to help you save the date. If you need to re-schedule an appointment, please call our office and arrange for a make-up appointment with our chiropractic assistants. We would prefer the make up appointment to be within the same week.

Thank you for your understanding. We greatly appreciate you as our patient and strongly desire excellent results and success for you!

I understand and agree to all the information written above.

Signature

Date Signed

-

Printed Name

Email

-

-

Today's payment will be made by:

Cash Check Credit Card Insurance

Insurance:

We will verify all insurances and your benefits per your agreement with your carrier. After verification the Doctor will give his recommendations and an appropriate plan will be designed for each individual. Please let the front-desk know if you have been in some type of accident or have been injured on the job. This will enable us to give you any and all information necessary to serve you completely and accurately.

Authorization for Care:

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all the services rendered to me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered.

Agreement:

My signature below signifies my agreement for payment in full on a cash basis if I have not provided all the necessary documents and information by the time of the second visit.

I have read and agree to the above statement.

Signature

Date Signed

-

Printed Name

Email

-

-

ACTIVITY LIMITS WORKSHEET

Name: _____

Date: _____

Duties Under Duress

Have you continued to do the following activities even though you have pain caused by your injury?

Please **circle** the following activities if you have pain while doing them, but you can still do them:

1. Work/employment
2. Laundry
3. Dishwashing
4. Vacuuming
5. Cleaning
6. Preparing meals
7. Mowing grass
8. Gardening
9. Taking out trash
10. Other house or yard work: _____
11. Attending school
12. Any other activity that you still can do but only with pain:
 - a. _____
 - b. _____
 - c. _____
 - d. _____

Loss of Enjoyment

Have you **stopped** doing any of the following activities as a result of your injuries? If so, circle:

1. Work
2. Laundry
3. Vacuuming
4. Dishwashing
5. Cleaning
6. Preparing meals
7. Mowing grass
8. Gardening
9. Taking out trash
10. Other house or yard work: _____
11. Attending school
12. Hobbies:
 - a. _____
 - b. _____
 - c. _____
13. Any other activity that you have stopped doing as a result of your injuries:
 - a. _____
 - b. _____
 - c. _____