



Automobile Accident Questionnaire UNRUH CHIROPRACTIC AND WELLNESS CENTER

Please answer all questions completely.

Date: _____

Name: _____, Date of Birth: _____

Address: _____, City: _____, State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____

Company Name: _____ Occupation: _____

Company Address: _____

Social Security #: _____ Sex: Female Male

Marital Status: S M D W, Who referred you to our office? _____

Please explain in detail how your accident happened: _____

Driver of other vehicle (if any) _____

Insurance Company: _____

Insurance Co Address: _____

Name and phone of person who has made contact with you: _____

Policy No: _____ Claim No: _____

Have you retained an attorney? Yes No Not Yet

If so, name, address & phone: _____

Date and Time of Accident/Injury: _____ / _____ /200_____ AM PM

You were heading North South East West on _____ (Street/Hwy)

Number of people in your vehicle: _____ Were police notified? Yes No

Did your head strike the windshield or an object? Yes No; Loss of Conscious? Yes No

If so, how long: _____. From which side were you struck: Front Back Left Right

Were you: Driver Passenger, Front Seat Back Seat, Using Seat Belts Using other

protective devices. Did you feel immediate pain? Yes No Later that day Next Day

When: _____. Where did you first feel pain? _____

Describe immediate treatment given: _____

Was any doctor consulted after the accident? Yes No

If so, Doctor's Name: _____ D.C. M.D. D.O. D.D.S. _____

Doctor's Diagnosis: _____

What treatment was given? _____

How often did you see the doctor? _____

Have you ever had any complaints in the involved area before? Yes No

If so, what complaints: _____

Before the injury were you capable of working on an equal basis with others in your age? Yes No

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

Since the injury, are your symptoms Improved? Getting worse? The same?



Application For Admission **UNRUH CHIROPRACTIC AND WELLNESS CENTER**

Congratulations! You have been fortunate enough to qualify for a **consultation** with the Doctor at no charge. However this does not mean that your case has been accepted. Your consultation today will determine if:

- A) You are a qualified candidate for this program and if
- B) Your condition is serious enough to warrant your case being accepted for treatment.

In the event you are qualified and your condition is serious enough to warrant being considered for treatment, if the Doctor is unavailable to treat you, your case will be referred to another clinic.

Today's Date _____

Name _____ Age _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

email _____

Birthday _____ Sex: M F Social Security _____

Best place to reach you: Home Work Cell

May we leave a voice mail message for you? Yes No

Employer _____

Occupation _____ Length of Employment _____

Marital Status: S M W D Spouse's Name _____ Spouse's

SS# _____ Names and Ages of Children _____

I (signature) _____ consent to allow the Doctor to speak with me and perform an examination (if necessary) in order to determine if I am a good candidate for Chiropractic Care and also to determine if he is willing to accept my case. It is also my understanding that the consultation is free of charge and that all examinations fees will be communicated before examination is performed.

If your insurance doesn't cover your care are you willing to pay out of pocket?

Yes No

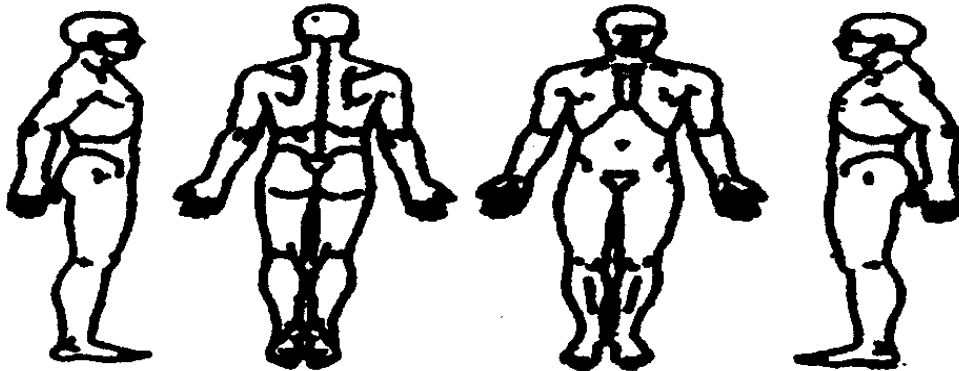
How Did You First Hear About Unruh Chiropractic and Wellness Center?



Patient Intake Form UNRUH CHIROPRACTIC AND WELLNESS CENTER

1. Is today's problem caused by Auto Accident Work Injury Other: _____

2. Indicate on the drawings below where you have pain/symptoms.



3. How often do you experience your symptoms?

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

4. How would you describe the type of pain?

- | | | |
|----------------------------------|--|--|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Shooting | <input type="checkbox"/> Shooting with motion |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Stiff | <input type="checkbox"/> Stabbing with motion |
| <input type="checkbox"/> Diffuse | <input type="checkbox"/> Numb | <input type="checkbox"/> Electric-like with motion |
| <input type="checkbox"/> Achy | <input type="checkbox"/> Tingly | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Sharp with motion | |

5. How are your symptoms changing with time?

- Getting worse Staying the same Getting better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem? _____

7. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem?

- | | | |
|--|---|---|
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Neurologist | <input type="checkbox"/> Primary Care Physician |
| <input type="checkbox"/> ER physician | <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> No one |

10. How long have you had this problem? _____

11. How do you think your problem began? _____

12. Do you consider this problem to be severe?

- Yes Yes, at times No

13. What aggravates your problem? _____

14. What concerns you the most about your problem; what does it prevent you from doing?

15. What is your:

Height: _____ Weight: _____ Age: _____ Occupation: _____

16. How would you rate your overall health?

- Excellent Very Good Good Fair Poor

17. What type of exercise do you do?

- Strenuous Moderate Light None

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

- Rheumatoid Arthritis Diabetes Lupus
 Heart Problems Cancer ALS

19. 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 "Now" column:

<u>Past</u>	<u>Now</u>	<u>Condition</u>	<u>Past</u>	<u>Now</u>	<u>Condition</u>	<u>Past</u>	<u>Now</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis, Eczema, Rash
<input type="checkbox"/>	<input type="checkbox"/>	Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness			
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite			
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain			
<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer			
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis			
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall Bladder Disorder			
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue			
<input type="checkbox"/>	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination			
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances			
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Gain / Loss			

For Women Only:

- Birth Control Pills
 Hormonal Replacement
 Pregnancy

Other: _____

20. List all of the medications you are currently taking: _____

21. List all of the over-the-counter medications you are currently taking: _____

22. List all of the surgical procedures you have had: _____

23. What activities do you do at work?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Sit: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |

24. What activities do you do outside of work? _____

25. Have you ever been hospitalized? Yes No If yes, why? _____

26. Have you had significant past trauma? Yes No If yes, describe: _____

27. Anything else pertinent to your visit today? _____

Patient Signature: _____

Date: _____



Terms of Acceptance

UNRUH CHIROPRACTIC AND WELLNESS CENTER

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: an adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: a state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: a misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the service of the health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ (print your name), have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature: _____ Date: _____