Today's Date: _____

Name: _____ Age: _____ Birth date: _____

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

Cell Phone: ( )_____ Home Phone: ( )_____ Work Phone: ( )_____

Why Chiropractic care? Chief complaint: _____ or Wellness: YES or NOT YET

Social Security #: _____ Male: _____ Female: _____

Occupation: _____ Employer: _____

Email: _____ Preferred method of contact: _____

Single: _____ Married: _____ Divorced: _____ Widowed: _____

Have you ever been adjusted by a Chiropractor? YES or **NO** **If so, how long ago?** _____

How were you referred to our office? _____

Your Health Profile

Welcome to Power Chiropractic and Wellness. Our goals are, first, to address the health concerns that brought you to this office, second, to offer you the opportunity to improve your overall health potential and well-being, and third, to answer any questions that you might have. Answering the following questions will give us a health profile allowing us to better assess your condition and help us address your current needs.

Childhood Years

Research is showing that many of the health challenges that we face today have their origins during our developmental years, some starting as early as birth. Please answer the following to the best of your ability.

	Yes	No
Was your birth C-section, suction or forceps?	☐	☐
Did you have any serious childhood illnesses?	☐	☐
Were you spanked or swatted as a child?	☐	☐
Did you experience any sports injuries as a child?	☐	☐
Any childhood falls or accidents? (car, crib, tree, bike, bed….)	☐	☐
Was there any prolonged use of medications such as antibiotics, inhalers, Ritalin?	☐	☐
Did you suffer any emotional trauma or significant loss as a child?	☐	☐
Were you checked for traumatic birth syndrome?	☐	☐

Adult Years

On a daily basis we experience physical trauma, chemical toxins and emotional stresses that can accumulate and result in a serious loss of our health potential. In most cases the effects are gradual, not even felt until they become serious.

	Yes	No
Do / Did you smoke?	☐	☐
Do / Did you drink alcohol?	☐	☐
Have you been involved in any accidents (car, work, sports, falls)?	☐	☐

If so, please describe (include dates): _____

_____

Do you participate in extreme sports? _____

Please list any surgery that you've had: _____

_____

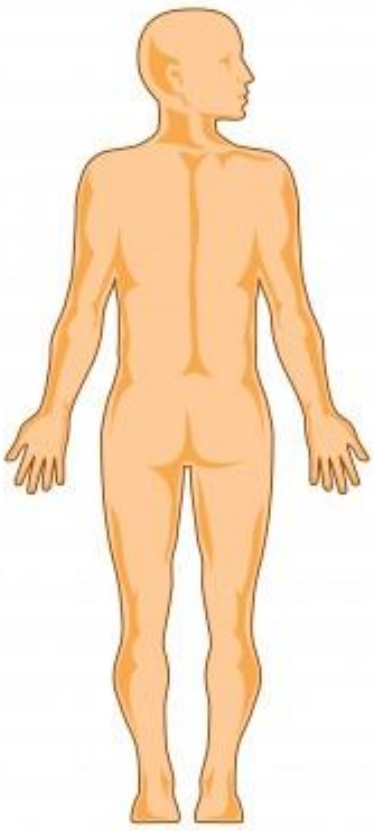
List all medications that you are taking: _____

Chief Complaint Assessment

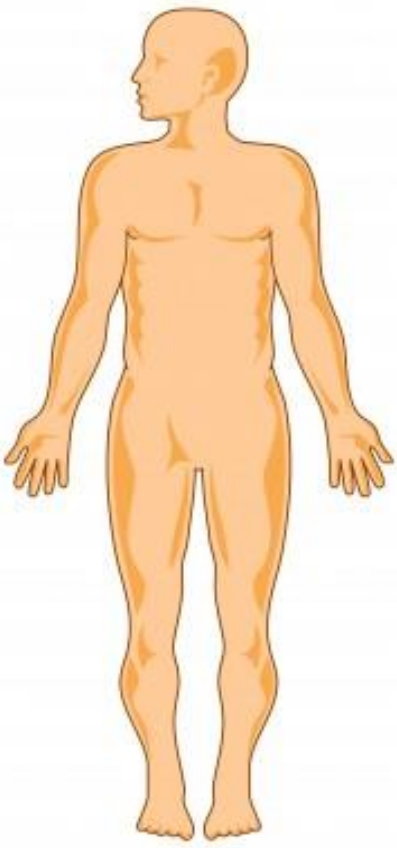
Pain Chart

Mark the areas on the picture below that best indicates the sensations that you are experiencing. Circle the appropriate body part and use the below symbols to indicate the type of sensations.

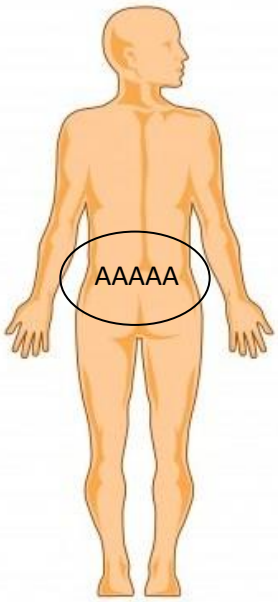
Sharp pain	Dull Ache	Numbness	Burning	Pins and Needles	Other
PPPPPPP	AAAAAA	NNNNNN	///////	++++++++++++	OOOOO



Rear



Front



Example

Circle a number below to indicate the level of intensity of your pain or discomfort on a scale of 1-10
(1 being lowest and 10 being highest)

Neck:	No pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Severe unbearable Pain
Mid Back:	No pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Severe unbearable Pain
Low Back:	No pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Severe unbearable Pain
_____:	No pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Severe unbearable Pain
_____:	No pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Severe unbearable Pain

Chief Complaint Assessment, Continued

On a scale of 1-10 rate your current state of health: (1=poor / 10=excellent) _____

List your chief complaints in order of severity:

1. _____ For how long: _____
2. _____ For how long: _____
3. _____ For how long: _____

Where is the pain? _____

Does the pain radiate: _____

Is your discomfort: ☐ Sharp ☐ Dull ☐ Burning ☐ Aching ☐ Comes and Goes ☐ Constant

Since your problem started, is it: ☐ About the same ☐ Getting better ☐ Getting worse

Does it interfere with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Leisure ☐ Family life

Other health care providers seen for this condition:

☐ Chiropractor:_____

☐ Medical Doctors:_____

☐ Other:_____

Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your your family and friends. If you have friends and family members that would be interested in having any of their health conditions or concerns evaluated by a Chiropractor, please mention their name and condition below:

Children:_____

Spouse:_____

Mother:_____

Father:_____

Brothers or sisters:_____

Goals For My Care

What would you like to achieve through Chiropractic care? (Check one or more below)

____ **Corrective Care**: Designed to eliminate or reduce the majority of the discomfort and stabilize the condition in the shortest amount of time. During this phase of care, visits may be frequent. Repeated visits could be required to reduce or eliminate the symptoms.

____ **Comprehensive Care**: Correct any underlying spinal injury as well as strengthening the muscles, improve spinal function and provide more complete or optimum healing of tissues and organ systems. Visits occur at reducing frequency and care is supplemented by exercises and modification of your daily and work habits. **Remember, many of the conditions for which people seek chiropractic care have developed over many years and therefore, it takes time to correct these conditions.**

____ **Wellness/Maintenance Care**: Maintain your improved health and spinal function, and prevent the return of the original condition once spinal correction has been attained. **Regular attention catches small problems before they become serious. Prevention saves time and money by helping you stay well.**

____ **I don't know!**: That's okay! Please feel free to ask questions at any point throughout your consultation and moving forward. **We are here to help you in any way that we can!**

Neurologic Scans and Systems Review

Your central nervous system (brain and spinal cord) is the master controller of your body. It controls the function of every cell, tissue and organ. The connection between your brain and your body is through the spinal nerves: sensory, motor and autonomic nerves. Your exam may reveal interference in the autonomic nervous system. This part of your nervous system controls the functions of organs, blood vessels and glands. Please review the following systems to determine if there may be a connection between your health profile and your nerve interference.

SYSTEM REVIEW: Place an (x) next to the symptoms you are experiencing, or that you have experienced.

Cervical Nerves

( ) eye strain	( ) red eyes	( ) vision problem	( ) weight gain
( ) ear infection	( ) ringing in the ear	( ) ear discharge	( ) crave sweets
( ) hearing loss	( ) sinusitis	( ) runny nose	( ) memory loss
( ) canker sores	( ) sore throat	( ) sore gums	( ) nightmares
( ) inner ear problems	( ) speech difficulty	( ) cavities	( ) tonsillitis
( ) hoarse/laryngitis	( ) headaches	( ) migraines	( ) emotional instability
( ) chronic fatigue	( ) dizziness	( ) anxiety	( ) insomnia

Upper Thoracic Nerves

( ) asthma	( ) chest pain	( ) pain over heart	( ) difficult breathing
( ) persistent cough	( ) bronchitis	( ) coughing phlegm	( ) coughing blood
( ) rapid heartbeat	( ) high blood pressure	( ) heart problems	( ) numbness in the hands/arms
( ) lung problems	( ) fluid retention	( ) pleurisy	( ) difficulty in swallowing
( ) nausea	( ) gall bladder attacks	( ) bloating	( ) intolerance to fatty foods

Mid Thoracic Nerves

( ) poor appetite	( ) excessive hunger	( ) gastric ulcer	( ) crave sweets
( ) difficult swallowing	( ) excessive thirst	( ) excessive thirst	( ) liver trouble
( ) vomiting food	( ) abdominal pain	( ) diarrhea	( ) immune deficiencies
( ) constipation	( ) pancreatitis	( ) black stool	( ) hypoglycemia

Lower Thoracic Nerves

( ) allergies	( ) sneezing	( ) overwhelmed	( ) digestive complaints after eating
( ) appendix problems	( ) bladder problems	( ) kidney problems	( ) testicular or ovarian problems
( ) bladder infections	( ) swollen ankles	( ) dizziness upon standing	

Lumbar Nerves

( ) bladder trouble	( ) IBS	( ) bad breath	( ) flatulence
( ) bowel problems	( ) painful urination	( ) infertility	( ) dark circles under eyes
( ) impotence	( ) dysmenorrhea	( ) prostate problems	( ) reproductive disorders
( ) female problems	( ) hemorrhoids	( ) varicose veins	( ) hormonal imbalances

Dr. Myles Crawford- Power Chiropractic & Wellness

To our valued patient,

We are truly sorry for the circumstances that have brought you to our office today. Our focus is providing you the best possible care so that you can recover as quickly as possible. To properly handle the billing of your case, it is essential you complete the forms attached and we have the following documents to proceed:

- Driver's License
- Your Auto Insurance Card and Declaration Page listing coverage
- At-Fault Party Insurance Information
- Attorney Information (if any)
- Accident/Incident Report

Injury Monkey, LLC will be handling your Personal Injury file. They are contracted by our office to ensure all documentation and necessary items are in place. They are also contracted to be patient advocates to ensure that you are educated and walked through this process. Your health is very important to us and we want to make sure you are taken care of.

PLEASE MAKE SURE YOU COMPLETELY ANSWER EVERY QUESTION, FILL IN EVERY BLANK AND BE SURE TO SIGN OR INITIAL EVERY SPACE THAT ITS REQUIRED. THESE FORMS ARE GOING TO BE ESSENTIAL WHEN IT COMES TIME TO SETTLE YOUR CASE OR IF YOU NEED TO OBTAIN AN ATTORNEY.

As you leave the office you will be given an information packet from Injury Monkey, LLC. Please contact their office within 24 hours of your first visit.

Thank you,

Dr. Myles Crawford and Staff

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Dr. Myles Crawford - Power Chiropractic & Wellness

PERSONAL INJURY/AUTOMOBILE ACCIDENT FINANCIAL POLICY

Our Personal Injury/Automobile Insurance Assignment Program is designed to render you immediate care and keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your auto insurance carrier on your behalf. Please remember, however, that you are ultimately responsible for payment of all services rendered to you regardless of insurance coverage or settlement status. Termination of care prior to your doctor's release will result in all balances being due immediately. Please notify us if you are using an attorney.

(initial) _____

MEDICAL PAYMENTS

"Medical Payments" or "Med-Pay" is part of your own auto insurance policy which will immediately cover the costs of your medical expenses given by a licensed health care provider and those of any passengers in your car, up to a certain limit, regardless of fault. Senate Bill 08-011, effective January 01, 2009, made Med-Pay benefits mandatory on all auto insurance policies unless specifically rejected in writing or declined during the application process. If payment is made by this method, and you are not at fault, your insurance premiums may not increase. Med-Pay is primary for services rendered to personal injury patients when available. We require you to use your "Med-Pay" if it is available on your policy.

(initial) _____

THIRD PARTY

Tennessee is currently an "at-fault" state regarding payment of claims resulting from an automobile accident or personal injury. This means the responsible party, or his or her insurance, should cover the cost of medically necessary treatment given by a licensed health care provider. Such claims are considered for payment when all treatment is complete and a settlement is reached with the third party. We will accept a doctor's lien.

(initial) _____

HEALTH INSURANCE

We will ***NOT*** bill your personal health insurance for personal injury. We will bill the primary which will be Med-Pay and/or third party insurance. Workers' Compensation will be billed directly. We do ask to have the information on record for continued care after you have been released.

(initial) _____

RESPONSIBILITY

I, _____ understand that I am primarily responsible for all medical bills and that in consideration for treatment from the motor vehicle accident, Dr. Myles Crawford agrees not to demand payment at the time of service, and I agree to pay Dr. Myles Crawford from the proceeds of any motor vehicle accident; and should I, my insurance company, third party insurance company or attorney fail to pay Dr. Myles Crawford from the proceeds, I agree to pay all court costs, collection costs and attorney fees associated with the delinquent account.

(initial) _____

I have read and understand the personal injury/automobile accident financial policy of Power Chiropractic & Wellness. I understand that I am ultimately responsible for any services rendered to me by Power Chiropractic & Wellness. I understand that if I terminate care outside my doctor's recommendations, any balances will be due immediately.

_____

Patient Name

_____ _____

Patient or Guardian Signature Date

Doctor's Lien

Dr. Myles Crawford-Power Chiropractic & Wellness

Patient's Name:_____ Date of Birth: _____

I do hereby authorize Dr. Myles Crawford to furnish to you with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct my insurance company, responsible party's insurance company and/or my attorney to pay directly to said doctor such sums as may be due and owing him for medical service rendered to me both by reason of settlement, judgment, or verdict as may be necessary to adequately protect said doctor. I hereby further give a LIEN on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to my attorney, or directly to said doctor as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

(initial) _____

The undersigned does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, third-party settlement, judgment, or verdict as may be necessary to adequately protect said doctor above named.

(initial) _____

By signing below, I understand and agree that in the event of default, I am legally liable for all costs of collection including collection fees, reasonable attorney fees, court costs, and all other costs related to the collection of debt.

(initial) _____

If my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Patient's Name: _____

Patient or Guardian's Signature: _____ Date:_____

_____

Address City St Zip

The undersigned being attorney of record for the above patient do hereby agree to observe all the terms of the above and agrees to withhold such sums form any settlement, third-party settlement, judgment or verdict as may be necessary to adequately protect said doctor named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Attorney Signature:_____ Date: _____

ASSIGNMENT OF INSURANCE BENEFITS AND PROCEEDS OF CLAIM

I am seeking treatment from Dr. Myles Crawford ("the Doctor") for injuries I suffered in a vehicle accident. In consideration of receiving such treatment, I hereby assign to the Doctor the following monies to which I am or may become entitled.

1. **Insurance Benefits**. I have an automobile insurance policy issued by _____ insurance company. I hereby assign to the Doctor any benefits to which I am or may become entitled under that policy. The amount assigned to the Doctor shall be limited to the amount of the charges for medical services rendered to me by the Doctor as treatment for injuries I received in the accident.

2. **Proceeds of My Claim Against Another Party**. At this time it has not yet been determined which party caused the accident in which I was injured.

It may be determined at a later time, by a court through litigation or by settlement negotiations between the parties and/or their insurance company representatives, that another party caused the accident in which I was injured and that the other party is therefore responsible for paying damages to me in an amount sufficient to cover, in whole or in part, the medical expenses I have incurred as a result of the accident. If this determination is made through a settlement, the settlement agreement may provide that an amount of money shall be paid to me by the insurance company for the other party, even though the settlement agreement states that the payment shall be made without an admission of liability by the other party.

If the insurance company for the other party agrees to pay, or is ordered by a court to pay, a specified sum to me for bodily injuries I incurred in the accident, I hereby assign to the Doctor a portion of the monies I am entitled to receive from the other party's insurance company, limited to the amount of the charges for medical services rendered to me by the Doctor as treatment for injuries I received in the accident.

I understand that I am at this time making an assignment of the proceeds of a potential claim against the other party involved in the accident and that this assignment will be effective only after a determination, either by a court or by a settlement, that the other party's insurance company will pay a specified amount of money to me.

I understand that a copy of this Assignment must be provided to the insurance company for the other party before it will be binding on that company and that the Doctor must provide to that insurance company appropriate evidence of the services provided to me and the charges for those services.

By making this Assignment to the Doctor, I am directing _____insurance company for the other party and/or my attorney _____to pay the assigned amount directly to the Doctor.

Dr. Myles Crawford- Power Chiropractic & Wellness
4117 Gallatin Rd
Nashville, TN 37216

I understand that if the insurance benefits and claim proceeds which are or become available to me are insufficient to cover the charges of the Doctor for the medical services provided to me, I am responsible for paying the balance of those charges.

I agree to notify the Doctor in writing at least thirty (30) days before changing this Assignment in any way.

_____ _____

Witness Print Patient Name

_____

Patient or Guardian Signature

Date: _____

Refer to judgment on Feb 5, 2015 by Supreme Court of Tennessee Action Chiropractic Clinic, LLC v. Prentice DelonHyler, ER AL.;Case No. M2013-01468-SC-R11-CV.

8.4.17

ACTIVITIES OF DAILY LIVING

Patient's Name:_____ Date: _____

Carrying Groceries	___No Effect	___ Painful(can do)	___ Painful(limits)	___Unable to Perform
Sit to Stand	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Climbing Stairs	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Pet Care	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Driving	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Extended Computer Use	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Household Chores	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Lifting Children	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Reading/Concentration	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Dressing	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Shaving	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Sexual Activities	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Sleep	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Static Sitting	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Static Standing	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Yard Work	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Walking	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Washing/Bathing	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Sweeping/Vacuuming	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Dishes	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Laundry	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Garbage	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Bending	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Care for Family	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Kneeling	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Other:_____	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Other:_____	___No Effect	___ Painful (can do)	___ Painful (limits)	___Unable to Perform
Lifting (weight limit)	Circle one:	10lbs 20lbs	30lbs 40lbs	50lbs

Please mark **P** for "in the **Past**", **C** for "**Currently**" have and **N** for "**Never**"

___ Headache	___ Pregnant(now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds,Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun	___ Heartburn
___ Jaw Pain,TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Press.
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Press.
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot/Knee Problems	___ Hearing Loss	___ Menstrual Problems	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Prob	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis(A,B,C)

8.4.17

Dr. Myles Crawford
Power Chiropractic & Wellness

PERSONAL INJURY/AUTOMOBILE ACCIDENT CLAIM INFORMATION FORM

For Office Use Only:

- ☐ Copy of Driver's License
- ☐ ***Signed*** Dr's Lien
- ☐ ***Signed*** Financial Policy
- ☐ ***Signed*** AOB/Settlement
- ☐ Copy of Personal Auto Insurance
- ☐ Copy of Per. Auto Declaration Page
- ☐ At-Fault Auto Info
- ☐ Attorney Info (if any)
- ☐ Accident Report
- ☐ Injury Monkey,LLC Business Card to Patient
- ☐ Injury Monkey,LLC Intro Letter to Patient

Verified by:_____ Date_____

Today's Date _____

Patient Name:_____

Guardian Name: _____

YOUR Auto Insurance Information

Name of Insurance Company: _____

Telephone #:_____

Name on Policy:_____

Policy #:_____

Claim#:_____

Claims Representative Name:_____

Claims Representative Phone #:_____

Do you have Medical Payments Benefits on your policy?

- ☐ Yes, Amount: _____
- ☐ No
- ☐ I don't know

Third Party/At Fault Driver Insurance Information

Third Party/Driver's Name:_____

Name of Insurance Company:_____

Telephone #:_____

Name on Policy:_____

Policy #:_____

Claim#:_____

Claims Representative Name:_____

Claims Representative Phone #:_____

Attorney (it is not always necessary to have an attorney for PI claims)

Name of Law Firm:_____

Name of Attorney:_____

Phone #:_____

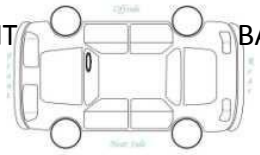
Patient / Guardian Signature:_____

8.4.17

Dr. Myles Crawford
Power Chiropractic & Wellness
ACCIDENT HISTORY QUESTIONNAIRE

Patient Name_____Date_____

1. Date of Accident:_____2. Time:_____AM/PM
3. Driver of Car:_____
4. Where were you seated?_____
5. Who owns the car?_____
6. Year & model of your car:_____
   Year & model of other car:_____
7. What was the approximate damage done to your car? $_____
8. Visibility at time of accident ☐Poor ☐Fair ☐Good ☐Other:_____
9. Road conditions at the time of accident:☐Icy ☐Rainy ☐Wet ☐Clear ☐Dark
   ☐ Other(describe)_____
10. Where was your car struck?

FRONT  BACK

In your own words, please describe accident:_____
_____
_____
_____
_____

11. Type of Accident:☐Head-on collision ☐Broad-side collision ☐Non-collision
12. At the time of the accident, recall what parts of your head or body hit what parts on the inside of thecar:_____
    _____
    _____
13. Did you see the accident coming? ☐Yes ☐No
14. Did you brace for impact?☐Yes ☐No
15. Were seat belts worn?☐Yes ☐No
16. Where shoulder harnesses worn?☐Yes ☐No
17. Does your car have headrests?☐Yes ☐No If yes, what was the position of those headrests compared to your head before the accident?
    ☐ Top of headrest even with bottom of head
    ☐ Top of headrest even with top of head
    ☐ Top of headrest even with middle of neck
18. Was your car braking?☐Yes ☐No
19. Was your car moving at the time of the accident? ☐Yes ☐No
20. If yes, how fast would you estimate you were going?_____mph
21. How fast would you estimate the other car was going?_____mph
22. Head/body position at the time of impact
    ☐ Head turned left/right ☐Body straight in sitting position
    ☐ Head looking back ☐Body rotated right/left
    ☐ Head straight forward ☐Other:_____
23. As a result of the accident you were:☐Rendered unconscious ☐In shock
    ☐ Dazed, circumstances vague ☐Other:_____

24. How was the shoulder harness adjusted? ☐ Loose ☐ Snug
25. Were you wearing a hat or glasses? ☐ Yes ☐ No
26. Could you move all parts of your body normally or as you could before the accident? ☐ Yes ☐ No
27. If no, what parts couldn't you move and why? _____
    _____
28. Were you able to get out of the car and walk unaided? ☐ Yes ☐ No
29. If no, why not? _____
30. Did you get any bleeding cuts? ☐ Yes ☐ No If yes, where? _____
31. Did you get any bruises? ☐ Yes ☐ No If yes, where? _____
32. Please describe how you felt:
    Immediately after the accident: _____
    Later that day: _____
    The next day: _____
33. Check symptoms apparent since the accident:

☐ Headache	☐ Neck pain/Stiffness	☐ Mid backpain
☐ Eyes Light Sensitive	☐ Pain Behind Eyes	☐ Dizziness
☐ Fainting	☐ Sleeping Problems	☐ Numbness in Fingers
☐ Numbness in Toes	☐ Loss of Smell	☐ Loss of Taste
☐ Loss of Memory	☐ Fatigue	☐ Breath Shortness
☐ Irritability	☐ Depression	☐ Ringing/Buzzing
☐ Loss of Balance	☐ Tension	☐ Cold Hands
☐ Cold Feet	☐ Diarrhea	☐ Constipation
☐ Chest Pain	☐ Nervousness	☐ Cold Sweats
☐ Anxious	☐ Facial Pain	☐ Clicking or Popping Jaw
☐ Low Back Pain	☐ Other _____	

34. Occupation: _____
35. Employer: _____
36. Have you missed time from work? ☐ Yes ☐ No
37. If yes, full time off work: _____ to _____
38. If yes, part time off work: _____ to _____
39. Did you seek medical help immediately after the accident? ☐ Yes ☐ No
    ☐ If yes, how did you get there? ☐ Ambulance ☐ Police ☐ Someone Else Drove Me
    ☐ Drove Own Car ☐ Other: _____
40. Doctor #1:Name: _____
41. First visit date: _____
42. Were you examined? ☐ Yes ☐ No
43. Were X-rays taken? ☐ Yes ☐ No
44. Did you receive treatment? ☐ Yes ☐ No ☐ Medications ☐ Braces ☐ Collars
45. If yes, what kind of treatment did you receive? _____
46. What benefits did you receive from the treatment? _____
47. Date of last treatment? _____
48. Doctor #2:Name: _____
49. First visit date: _____
50. Were you examined? ☐ Yes ☐ No
51. Were X-rays taken? ☐ Yes ☐ No
52. Did you receive treatment? ☐ Yes ☐ No ☐ Medications ☐ Braces ☐ Collars
53. If yes, what kind of treatment did you receive? _____

_____ _____

Patient / Guardian Signature Date