LONGNER
Chiropractic

PERSONAL

NAME: ______________________

ADDRESS: ______________________

HOME PHONE: ______________ CELL PHONE: ______________

E-MAIL ADDRESS: ______________________

DATE OF BIRTH: ______________ SOCIAL SECURITY NO.: ______________

EMPLOYMENT

NAME OF EMPLOYER: ______________________

JOB TITLE: ______________ WORK PHONE: ______________

INSURANCE COVERAGE

AUTO INSURANCE

NAME OF COMPANY: ______________________

CLAIM #: ______________ AGENTS NAME: ______________

POLICY HOLDER: ______________________

POLICY #: ______________

INS. COMPANY PHONE #: ______________ FAX #: ______________

ATTORNEY

COMPANY: ______________________

NAME: ______________________

ADDRESS: ______________________

PHONE #: ______________ FAX #: ______________

NATURE OF ACCIDENT

1. DATE OF ACCIDENT______________________________ TIME OF DAY____________________________
2. WERE YOU: ___DRIVER ___PASSENGER ___FRONT SEAT ___BACK SEAT
3. NUMBER OF PEOPLE IN THE VEHICLE? ___ WERE YOU WEARING SEAT BELTS? ___YES ___NO
4. WHAT DIRECTION WERE YOU HEADED? ___NORTH ___SOUTH ___EAST ___WEST
   ON(NAME OF STREET)____
5. WHAT DIRECTION WAS THE OTHER VEHICLE HEADED? ___NORTH ___SOUTH ___EAST ___WEST
   ON(NAME OF STREET)____
6. WERE YOU STRUCK FROM: ___BEHIND ___FRONT ___LEFT SIDE ___RIGHT SIDE
7. APPROXIMATE SPEED OF YOUR CAR ___MPH OTHER CAR ___MPH
8. WERE YOU KNOCKED UNCONCIOUS? ___YES ___NO IF YES FOR HOW LONG? ______________
9. WERE POLICE NOTIFIED?
   ___YES___NO
10. IN YOUR OWN WORDS, PLEASE DESCRIBE ACCIDENT:
    ____
    ____
    ____
    ____
11. DID YOU HAVE ANY PHYSICAL COMPLAINTS (**BEFORE THE ACCIDENT**)? ___YES ___NO
    IF YES, PLEASE DESCRIBE IN DETAIL: ____
    ____
    ____
    ____
12. PLEASE DESCRIBE HOW YOU FELT:
    a. **DURING** THE ACCIDENT: ____
    b. **IMMEDIATELY** AFTER THE ACCIDENT: __________________________________
    c. **LATER** THAT DAY: ____
    d. THE **NEXT** DAY: ____
13. WHAT ARE YOUR **PRESENT** COMPLAINTS AND SYMPTOMS?
    ____
    ____
14. DO YOU HAVE ANY CONGENITAL (FROM BIRTH) FACTORS WHICH RELATE TO THIS PROBLEM? ___YES ___NO
    IF YES, PLEASE DESCRIBE:
    ____
    ____
15. DO YOU HAVE ANY PREVIOUS ILNESS WHICH RELATE TO THIS CASE? ___YES ___NO
    IF YES, PLEASE DESCRIBE:
    ____
    ____
16. 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(IES) RECEIVED.
    ____
    ____
    ____
17. WHERE WERE YOU TAKEN AFTER THE ACCIDENT?
    ____

18. HAVE YOU BEEN TREATED BY ANOTHER DR SINCE THE ACCIDENT? ___YES ___NO

IF YES, PLEASE LIST DR'S NAME AND ADDRESS: ______________________________

____

WHAT TYPE OF TREATMENT DID YOU RECEIVE?

____

____

19. SINCE THIS INJURY OCCURRED, ARE YOUR SYMPTOMS: ___IMPROVING ___GETTING WORSE ___SAME

20. **CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:**

__HEADACHE	__IRRITABILITY	__NUMBNESS IN TOES	__FACE FLUSHED	__FEET COLD
__NECK PAIN	__CHEST PAIN	__SHORTNESS OF BREATH	__BUZZING IN EARS	
__HANDS COLD	__NECK STIFF	__DIZZINESS	__FATIGUE	
__LOSS OF BALANCE	__STOMACH UPSET	__SLEEPING PROBLEMS	__HEAD SEEMS TOO HEAVY	
__DEPRESSION	__FAINTING	__COMPENSATION	__BACK PAIN	
__PINS. NEEDLES IN LEGS		__LIGHTS BOTHER EYES	__LOSS OF SMELL	__FEVER
__PINS. NEEDLES IN ARMS		__COLD SWEATS	__NERVOUSNESS	__TENSION
__NUMBNESS IN FINGERS		__EARS RING	__DIARRHEA	

21. **SYMPTOMS OTHER THAN ABLOVE:**______________________________

22. HAVE YOU LOST TIME FROM WORK AS A RESULT OF THIS ACCIDENT? ___YES ___NO

IF YES, PLEASE COMPLETE THIS QUESTION.

A. LAST DAY WORKED: ______________________________

B. TYPE OF EMPLOYMENT: ______________________________

C. PRESENT SALARY: ______________________________

D. ARE YOU BEING COMPENSATED FOR TIME LOST AT WORK? ___YES ___NO

IF YES, PLEASE STATE TYPE OF COMPENSATION YOU ARE RECEIVING:

____

____

23. DO YOU NOTICE ANY ACTIVITY RESTRICTIONS AS A RESULT OF THIS INJURY? ___YES ___NO

IF YES PLEASE DESCRIBE IN DETAIL:

____

____

OTHER PERTINENT INFORMATION:

____

____

____

SIGNATURE: ______________________________ **Date:** ______________

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FRI:_____

FOR EACH ITEM BELOW, CIRCLE ***ONE*** OF THE NUMBERS WHICH MOST CLOSELY DESCRIBES YOUR CONDITION RIGHT NOW

NAME:_______________________________ DATE:_______________________

Item	0	1	2	3	4
1. **PAIN INTENSITY**	NO PAIN	MILD	MODERATE	SEVERE	WORST EVER
2. **SLEEPING**	PERFECT SLEEP	MILDLY DISTURBED	MODERATELY DISTURBED	GREATLY DISTURBED	TOTALLY DISTURBED
3. **PERSONAL CARE** (WASHING,DRESSING,ECT.)	NO PAIN OR RESTRICTION	MILD PAIN NO RESTRICTION	MODERATE NEED TO GO SLOW	MODERATE NEED ASSISTANCE	SEVERE 100% ASSISTANCE
4. **TRAVEL** (DRIVING, ECT.)	NO PAIN ON LONG TRIPS	MILD PAIN ON LONG TRIPS	MODERATE PAIN ON LONG TRIPS	MODERATE PAIN ON SHORT TRIPS	SEVER PAIN ON ON SHORT TRIPS
5. **WORK** (JOB OR HOME)	CAN DO USUAL WORK	CAN DO USUAL WORK NO EXTRA WORK	CAN DO 50% OF USUAL WORK	CAN DO 25% OF USUAL WORK	CANNOT WORK
6. **RECREATION**	CAN DO ALL ACTIVITIES	CAN DO MOST ACTIVITIES	CAN DO SOME ACTIVITIES	CAN DO A FEW ACTIVITIES	CAN DO NO ACTIVITIES
7. **FREQUENCY OF PAIN**	NO PAIN	OCCASIONAL PAIN 25% OF THE DAY	INTERMITTEN PAIN 50% OF THE DAY	FREQUENT PAIN 75% OF THE DAY	CONSISTANT PAIN 100% OF THE DAY
8. **LIFTING**	NO PAIN	INCREASED PAIN WITH HEAVY WEIGHT	INCREASED PAIN WITH MODERATE WEIGHT	INCREASED PAIN WITH LIGHT	INCREASED PAIN WITH ANY WEIGHT
9. **WALKING**	NO PAIN AT ANY DISTANCE	INCREASED PAIN AFTER 1 MILE	INCREASED PAIN AFTER ½ MILE	INCREASED PAIN AFTER ¼ MILE	INCREASED PAIN WITH ANY WALKING
10. **STANDING**	NO PAIN AFTER AFTER SEVERAL HOURS	INCREADED PAIN AFTER SEVERAL HOURS	INCREASED PAIN AFTER 1 HOUR	INCREASED PAIN AFTER ½ HOUR	INCREASED PAIN WITH ANY STANDING

WEIGHT

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Write the corresponding letter directly on the area where you feel the pain.

NAME: ______________________________ DATE: ____________________

A= ACHE | B=BURNING | N=NUMBNESS

P= PINS& NEEDLES | S=STABBING | T= TINGLING

O=OTHER