

INTRODUCTION PATIENT CASE HISTORY

Patient No: _____

Date: _____

Name (Mr. Mrs. Miss Ms.) _____
(Last, First, MI)

Address: _____ City _____ State _____ Zip _____

Home Phone: () _____ Mobile: () _____ Work Phone: () _____

Email Address: _____ Married _____ Single _____ Other _____

Social Security No.: _____ - _____ - _____ Date of Birth: ____/____/____

Occupation: _____ Employer: _____

Name of your Insurance Company: _____

Primary Insurance Holder: _____ Primary Holders Date of Birth: _____

Previous Chiropractic Care? Yes No Doctor's Name: _____

Major Complaint: _____ Began When and How _____

Any Recent Surgeries _____ Any Recent Accident's _____

Medications _____ Allergies RX _____

Physicians Contact _____

Who (or what source) referred you? _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

AUTOMOBILE ACCIDENT QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Patient _____ Date _____
Sex _____ Marital Status _____ No. _____
Date of Birth _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Occupation _____

Social Sec. # _____ Business Phone _____ Company Name _____

Company Address _____

Please explain in detail how your accident happened? _____

Driver of other vehicle (if any) _____ Date of Birth _____

Insurance Company _____ Address _____ Phone No: _____

Policy No. _____

Claim No. _____

Name of person who has made contact with you _____

Name of driver of vehicle in which you were injured (self or other) _____

Insurance Company _____ Address _____ Phone No: _____

Policy No. _____

Claim No. _____

Name of Person who has made contact with you _____

Have you retained an attorney? Yes No Not Yet

If so, his/her name, address & phone # _____

Give time and date present injury occurred _____ AM PM ____/____/____

You were heading? North South East West on _____ (street or highway)

Number of people in your vehicle _____

Were police notified? Yes No Did head strike windshield or object? Yes No

Were you knocked unconscious Yes No If so, for how long _____

You were struck from? Behind Front Left Side Right Side

You were? Driver Passenger Front seat Back seat Using seat belts Other protective devices

Did you feel pain immediately after the accident? Yes No Later that day Next day When _____

Where did you feel pain immediately after the accident? _____

Where were you taken after the accident? _____

Was treatment given? _____

Was any doctor consulted after the accident? Yes No

If so, give 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? _____

How long did you see the doctor? _____

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

If so, what were the complaints? _____

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

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

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

HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date: _____

Patient: _____ No.: _____

MUSCULO SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

ARE YOU PREGNANT?

YES NO

GASTRO-INTESTIONAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting Blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

CARDIO-VASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw Pain

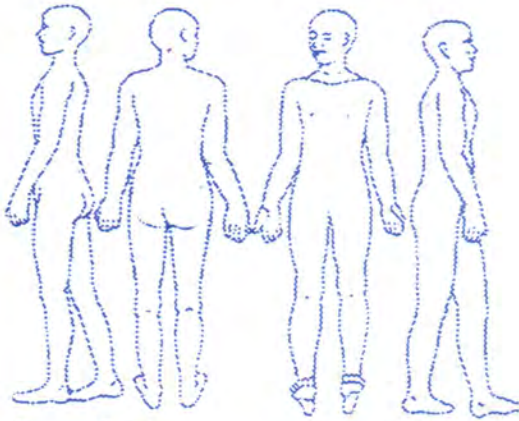
NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

HABITS

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Drug Abuse
- _____

SYMPTOM LOCALIZATION



P ___ Pain T ___ Tender
 N ___ Numb H ___ Hypoesthesia
 S ___ Spasm

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature _____

..... DO NOT WRITE BELOW THIS LINE.....

Patient Accepted? Yes No Doctor's Signature _____

Acknowledgement of Receipt of Notice

HealthWise Chiropractic 8421-T East 61st Street Tulsa, OK. 74133

Jessica Montesano, Chiropractor 918-461-9490

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Yes No (circle one) I would like to receive a copy of any amended Notice of Privacy Practices

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate.

Relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient

Name of Patient: _____

For Office Use Only:

Signed form received by: _____

Acknowledgment refused:

Efforts to obtain:

Reasons for refusal:
