COLLIN | CHIROPRACTIC

Patient Information

Patient Name: First:_____ MI:____ Last:_____ Nickname: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

DOB:___/___/___ **Age**:_____ **Sex**: ☐ Male ☐ Female

Address: Street: _____ City: _____ State: ____ ZIP: _____

Phone: Cell:_____ Home:_____ **Email:**_____

Occupation:_____ Employer:_____

How did you hear about us (check one):

☐ Friend/ Family: Name:_____ ☐ Groupon ☐ Another Provider: Dr._____ ☐ Internet

☐ Promo Event ☐ Staff ☐ Gym ☐ The Joint (Which location did you come from?): _____

Personal Injury/ Auto (only)

Please bring the police report and any pictures that you may have.

At Fault Insurance:_____ **Claim Number:**_____ **Adjuster Phone Number:**_____

Does your insurance pay medical bills regardless of who is at fault? ☐ Yes ☐ No **Date of the Accident**:___/___/___

What was the make, model and year of the car you were driving?:_____

Were you the: ☐ Driver ☐ Passenger **If passenger, where were you sitting?:** ☐ Front seat ☐ Right rear ☐ Left rear

Was your vehicle moving or stopped? Check all that apply): ☐ Preceding along ☐ stopped ☐ stopped at intersection

☐ stopped in traffic ☐ stopped at a light ☐ stopped at a stop sign ☐ making a left turn ☐ making a right turn

☐ slowing down ☐ parking ☐ accelerating

What part of your car did the other car hit?:_____

What was the make, model and year of the car that hit you?:_____

Was it: ☐Light ☐ Dark ☐ Foggy **Road conditions?:** ☐ Icy ☐ Wet ☐ Dry

Did you anticipate the collision/ have time to "brace for impact"? ☐ yes ☐ no

Were you wearing a seatbelt? (this will not count against you): ☐ no ☐yes

Where was the headrest? ☐ top of my head ☐ bottom of my head ☐ even with my neck ☐ even with my upper back

Where both of your hands on the steering wheel during the crash? ☐ yes ☐ only left ☐ only right

Where were you looking during the crash? ☐ Forward ☐ Left ☐ Right ☐ Up ☐ Down

Did you lose consciousness? ☐ yes ☐ no **Did the airbags deploy?** ☐ yes ☐ no **Did the seat break?** ☐ yes ☐ no

Please list any objects thrown around the car:_____

I certify that the above information is true to the best of my knowledge. _____ _____
Initial here *Date*

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Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Personal Health History:

List any medical problems that other doctors have diagnosed:_____

_____

_____

Surgeries/ Hospitalizations (please list the year, reason and hospital):_____

_____

_____

List prescribed drugs and over-the-counter medications (if you need more room, please attach)_____

_____

_____

Family Health History:
Please list any significant health problems and the age of any of the following family members

Mother:_____

Father:_____

Siblings:_____

_____

_____

Children:_____

_____

_____

Would you like more information about our other services here at Collin Chiropractic, such as (check all that apply):

☐ Physical Therapy ☐ Massage ☐ Weight Loss ☐ Digestive Supplements ☐ Pain Management

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Collin Chiropractic and insurance company to release any information required to process my claims.

_____ _____

Patient/ Guardian Signature *Date*