FLOW CHIROPRACTIC

PATIENT INFORMATION

Date_____
Name_____
Address_____
City _____ State____ Zip_____
Sex □ M □ F Age ____
Birth Date_____
□ Single □ Married □ Widowed □ Divorced
SS#_____ (This line is required)
Occupation_____
Employer_____
Employer Address_____
City _____ State _____ Zip_____
Spouse's Name _____
Home _____ Cell _____
Work _____ Ext _____
Best time & place to reach you _____
Email Address _____
May we send cards, promotions, etc. to you?
□Yes □No
IN CASE OF EMERGENCY, CONTACT:
Name _____
Relationship _____
Home # _____ Cell# _____
Work # _____ Ext _____

Whom may we thank for referring you to our office?

All information **MUST** be filled out in order for us to process your claims correctly.

YOUR AUTO INSURANCE INFORMATION

Name of Insured: _____
Birth Date: _____(this line is required!)
SS#:_____(this line is required!)
Relationship to Injured: _____
Auto Insurance Company: _____
ID or Policy #: _____
Claim# :_____(this line is required!)
Contact Person _____
Phone Number_____
Attorney Name (If Applicable) _____

ACCIDENT INFORMATION

Is condition due to an accident? □Yes □No
Date of Accident_____
Type of Accident □Auto □Work □Home □Other

Office Use Only

Name of Adjuster: _____
Phone Number: _____Ext_____
Fax Number: _____
Address: _____
_____
Has a Lien been signed? □Yes □No

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Flow Chiropractic will aid in preparation of any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Flow Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

I am aware and agree to pay a minimum finance charge of 1.5% per month (annual percentage rate of 18%) or a minimum of $2.00, whichever is more on any amount not paid after 30 days. If collection is made by suit or otherwise, patient and/or responsible party agree to pay interest until paid, collection costs of 50% of the remaining balance, all attorney fees and court costs. If any portion of this bill or the providers' services is disputed, I agree to submit myself to mediation or arbitration and will pay the costs of doing so.

NAME (PRINT)_____ SIGNATURE _____ DATE_____
(Parent if patient is under 18 years of age)

Injury Basic Information

Patient name: _____ Today's Date: _____

1. Description of Accident/Injury/Onset (Please enter in your own words a full description on accident/injury/onset)

2. Your condition during and immediately after injury/onset
   (Please enter the details of your condition during and immediately after injury/onset)

3. Current conditions/symptoms (Please describe what you are currently experiencing)

4. Have your symptoms changed from immediately following the crash until now?
   - o Better
   - o Worse
   - o About the same

   Describe:

Automobile Crash Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

Your vehicle type:	Your vehicle position:	What was your vehicle doing at the time of the crash:	
☐ Car	☐ Driver	☐ Stopped at intersection	☐ Stopped at light
☐ Van	☐ Front Passenger	☐ Stopped in traffic	☐ Parking
☐ Pickup	☐ Rear _____	☐ Making a right turn	☐ Accelerating
☐ SUV	☐ Other:	☐ Making a left turn	☐ Proceeding along
☐ Other:			☐ Slowing down
			☐ Other:

Time of crash:	Visibility at time of crash:	Road conditions at time of crash:	Point of impact:
I felt a _____	☐ Poor	☐ Icy	☐ Head-on
☐ Mild	☐ Fair	☐ Wet	☐ Rear-end
☐ Moderate	☐ Good	☐ Sandy	☐ Left Front
☐ Severe	Who hit who?	☐ Dark	☐ Right Front
Impact	You hit other vehicle or other vehicle hit you?	☐ Clean and Dry	☐ Left Rear
			☐ Right Rear

Body position: Did you see the crash coming? Y N Were you braced for impact? Y N Did you have your seat belt on? Y N Did you have your shoulder harness on? Y N	Does your vehicle have headrests: Y N Was the position of your head rest at time of impact: ☐ Even with the top of your head ☐ Even with the bottom of your head ☐ Middle of neck	What was the direction of your head at the time of impact? ☐ Facing straight forward ☐ Turned to the right ☐ Turned to the left
Did driver air bags deploy? Y N	Did passenger side airbags deploy? Y N	Dis side airbags deploy? Y N

Enter any additional information here that is not covered by the above check offs.:

Did your body strike the inside of your vehicle? Y N
If yes, describe: _____
Did you lose consciousness during the injury? Y N
If yes, for how long? _____
Your vehicle's estimated damage: _____
Damage to their vehicle:
- ☐ Mild
- ☐ Moderate
- ☐ Totaled

Did police show up at the scene? Y N
Was an accident report filled out? Y N

Circle any symptoms right after and a few days following:

Headache	Dizziness	Mid-Back Pn	Cold Hands
Neck pain	Nausea	Low Back Pn	Cold Feet
Neck stiffness	Confusion	Nervousness	Diarrhea
Fainting	Fatigue	Loss of taste	Depression
Ringing in ears	Tension	Toe Numb	Anxious
Loss of smell	Irritability	Constipation	Chest pain
Pain behind eyes	Shortness of breath	Sleeping issues	
Other:			

Where did you go after the crash?

Home	Work	ER	Doctor

How did you get there?

Self	Somebody else	Ambulance

Were x-rays done? Y N
Body part x-ray?
X-rays revealed: _____
Was lab work done? Y N
Treatment done?

Treatment History:
Dr. _____ First visit date: _____
Specialty: _____ X-rays done? Y N
Type of treatments received: _____
How many visits? _____
Currently Treating? Y N
Did treatments benefit you? Y N
Last visit date:

Past Medical History and Review of Systems

Review of Systems

Heart Attack……	No	Yes	Emphysema…….	No	Yes	Asthma……..	No	Yes
Heart Failure……...	No	Yes	Coughing Up Blood	No	Yes	Unplanned Weight Loss.	No	Yes
Heart Disease…….	No	Yes	Tuberculosis……	No	Yes	Enlarged Lymph Nodes..	No	Yes
Osteoporosis……..	No	Yes	Pneumonia……..	No	Yes	Celiac / Crohn's / Colitis.	No	Yes
Multiple Sclerosis…...	No	Yes	Severe Heart Burn.	No	Yes	Anesthesia Problems…..	No	Yes
Parkinson's…….	No	Yes	Hiatal Hernia……	No	Yes	Depression / Anxiety…...	No	Yes
High Blood Pressure.	No	Yes	Stomach Ulcers…..	No	Yes	Auto-Immune Disorders.	No	Yes
Poor Circulation…….	No	Yes	Hepatitis……..	No	Yes	Eye Disorders……..	No	Yes
High Cholesterol……	No	Yes	Jaundice……..	No	Yes	Hearing Loss……	No	Yes
Stroke……..	No	Yes	Kidney Infection…..	No	Yes	Menstrual Problems……	No	Yes
Paralysis……..	No	Yes	Irritable Bowel…….	No	Yes	Prostate Problems……..	No	Yes
Severe Headaches…	No	Yes	Thyroid Problems…	No	Yes	Pacemaker……	No	Yes
Seizures……..	No	Yes	Diabetes……...	No	Yes	Urinary Problems…….	No	Yes
Blackout Spells……..	No	Yes	Arthritis / Joint Pain	No	Yes	Cancer _____		
Head Injury…….	No	Yes	Skin Disorders…….	No	Yes	Other _____		
Meningitis……	No	Yes	Acid Reflux……..	No	Yes	Other _____		

Past History

Please list any other medical problems not listed above:

_____

_____

_____

Please list any previous **Surgeries:**

_____

_____

_____

Allergies

Are you allergic to (circle):

Wheat / Gluten	Lotions
Dairy	Laundry Detergent
Essential Oils	Medicine / Vitamins: _____
Latex	Other: _____

Health Choices

- Do you SMOKE / use tobacco? Daily Weekly Occasionally Never
- Do you drink ALCOHOL? Daily Weekly Occasionally Never
- Do you drink COFFEE / CAFFEINE? Daily Weekly Occasionally Never
- Do you drink SODA? Daily Weekly Occasionally Never
- Do you eat FAST FOOD? Daily Weekly Occasionally Never
- Do you eat SUGAR Daily Weekly Occasionally Never
- Do you EXERCISE? Daily Weekly Occasionally Never
- WORK Activity: Sitting Standing Light Labor Heavy Labor
- Daily ENERGY Level: Low Moderate High
- Cups of WATER per day: 0 1 2 3 4 5 6 7 8 9
- Do you eat FRUIT? Daily Weekly Occasionally Never
- Do you eat VEGGIES? Daily Weekly Occasionally Never
- Stress Level: Low Moderate High
- Do you sleep well? N Y I sleep on: Back Side Stomach How many hours? _____

Goals For Your Care

People see chiropractors for a variety of reasons, and our office offers different types of care. Please select the type of care that you are looking for as you begin your health journey with us.

___ Crisis Care / Symptom-based Care: Short-term, symptomatic relief of pain or discomfort

___ Corrective Care: Correct the underlying cause of your health problems, including symptom relief

___ Wellness Care: Once you are truly well, maintain the highest state of health possible

___ *I want the doctor to select the type of care appropriate for my condition.*

Family Health History

Circle those involving family members: M=Mother F=Father S=Sibling G=Grandparent			
Cancer, Type: _____ M / F / S / G	Depression M / F / S / G	Diabetes M / F / S / G	Back Problems M / F / S / G
Heart Disease M / F / S / G	Liver Disease M / F / S / G	High Blood Pressure M / F / S / G	High Cholesterol M / F / S / G
Lung Problems M / F / S / G	Scoliosis M / F / S / G	Neck Problems M / F / S / G	Osteoporosis M / F / S / G
Seizures M / F / S / G	Osteoarthritis M / F / S / G	Rheumatoid Arthritis M / F / S / G	Other: _____ M / F / S / G