The Health Connection
CHIROPRACTIC • ACUPUNCTURE • MASSAGE

Injury Intake

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. Here at this office we offer Chiropractic, Acupuncture and Massage; this health information can be used for any and all of the above. If we believe that we cannot assist you with your health care needs, we will be more than happy to refer you to the appropriate health care professional. If you have any questions, please ask. Thank you.

First Name: **Middle Initial:**

Last Name:

Date of Birth: / / Age: **Social Security #:**

Gender: [ ] Male [ ] Female **Height:** **Weight:** **Marital Status:** [ ] Married [ ] Single [ ] Life Partner [ ] Widow(er)

Address: **City/State/Zip:**

Home Phone: **Work Phone:** **Cell Phone:**

Email:

As a courtesy, we utilize EMAIL or TEXT MESSAGE for appointment reminders for our patients. Please choose ONE.

☐ **Text message (phone number):** ____**Carrier:**__________________________________

☐ **E-mail address listed above**

Occupation: **Employer:**

Emergency Contact: Relationship & Phone:

Primary Care Provider: **Phone:**

INSURANCE COMPANY INFORMATION

Insurance Company: Claim #:

Address:

Adjuster Name: Phone:

OTHER DRIVER'S INSURANCE INFORMATION

Insurance Company: Claim #:

Address:

Adjuster Name: Phone:

Signature: ____ Date: ______________________

Modified: 01/01/2015 *Please note that all information is strictly confidential.*

Date of accident: ______/______/______ Time of accident: am/pm

Location of accident (street/highway) in (city)

As a □ driver □ passenger □ pedestrian □ bicyclist Was anyone else in the car with you?

Drivers License #

Type of accident: Auto / Slip or Fall / Work related

Incident Report Taken: □ Yes □ No If yes, we will need a complete copy of the report

Police Report Taken: □ Yes □ No If yes, we will need a complete copy of the report

Have you retained the services of an attorney? □ Yes □ No

If yes, Attorney's name: Phone:

Address: Fax:

Have you missed time from work? □ Yes □ No □ Have been unable to work since accident

If yes, please list the dates or time range you have missed:

SYMPTOMS FROM ACCIDENT

Please describe specifically how you felt immediately after the accident:

Later that □ day □ night

The next day(s)

Did you get bleeding cuts or bruises? □ Yes □ No

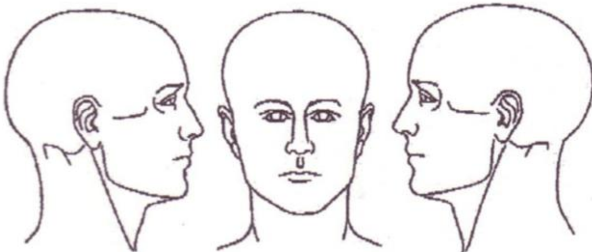
If yes, please list in detail

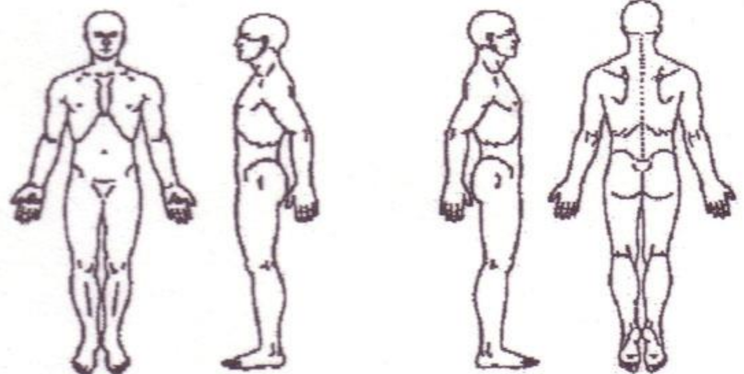
Check Symptoms Apparent SINCE Accident:

□ Headache	□ Dizziness	□ Loss of memory	□ Sleeping problems	□ Constipation	□ Neck pain
□ Fainting	□ Fatigue	□ Numbness in toes	□ Chest pain	□ Mid-back pain	□ Ringing in ears
□ Tension	□ Nervousness	□ Low back pain	□ Loss of balance	□ Shortness of breath	□ Cold hands
□ Cold feet	□ Light sensitive	□ Loss of smell or taste	□ Anxious	□ Diarrhea	□ Depression

□ Other ____________________________________

Please indicate any areas causing pain or distress:





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The Health Connection
601 South Pine Street #201 ♦ Tacoma, WA 98405 ♦ Office: (253) 396-1000 ♦ Fax: (253) 396-1012

ACTIVITIES OF DAILY LIVING

Do you notice any daily activities that are different now than from before the accident? ☐ Yes ☐ No

If yes, list them specifically: Activities you are UNABLE to do

Activities that are PAINFUL to do

Activities that are DIFFICULT to do

PAIN INTENSITY

Please rate on a scale of 1-10 (1 being the least pain, 10 being the most pain)

☐ Neck Pain ___________ ☐ Mid back Pain _____________ ☐ Low back Pain ____________ ☐ Other:________________

☐ Sleeping ____________ ☐ Personal care ______________ ☐ Traveling ________________ ☐ Work_________________

☐ Lifting ______________ ☐ Walking ___________________ ☐ Standing_________________ ☐ Recreation ____________

FREQUENCY OF PAIN

☐ No pain ☐ Occasional 25% ☐ Intermittent 50% ☐ Frequent 75% ☐ Constant 100%

PAST MEDICAL HISTORY

Please note dates of each:

☐ Mental Illness ☐ Diabetes ☐ Hepatitis ☐ HIV+ ☐ AIDS ☐ Herpes
☐ High Blood Pressure ☐ Heart Disease ☐ Asthma ☐ Allergies ☐ Stroke ☐ Arthritis
☐ Chronic Fatigue ☐ Gall Stones ☐ Venereal Disease ☐ Osteoporosis ☐ Seizures ☐ Parasites
☐ Mononucleosis ☐ Rheumatic Fever ☐ Thyroid Problems ☐ Kidney Stones ☐ Ulcers ☐ Cancer
☐ Other _____________________________________

Surgeries (types & dates):

Significant Traumas:

Significant Dental Work:

Other:

Allergies (drugs, chemicals, foods, etc.):

Occupational Stress (chemical, physical, psychological):

Birth History (prolonged labor, forceps, premature, etc.):

FAMILY MEDICAL HISTORY

☐ Cancer ☐ Heart Disease ☐ Asthma ☐ Diabetes ☐ Stroke
☐ Allergies ☐ High Blood Pressure ☐ Seizures ☐ Other _____________________________________

What medications and/or supplements are you currently taking?

Thank you for taking the time to fill out this form thoroughly. It will help us serve you better.

Signature: ____ Date: ______________________________

Modified: 01/01/2015 *Please note that all information is strictly confidential.*