The Health Connection
CHIROPRACTIC • ACUPUNCTURE • MASSAGE

Injury Registration

Today's Date (MM/DD/YYYY)

Gender
◯ Male ◯ Female

Last Name

Social Security Number

First Name | Middle Name (Or Initial) | Date of Birth (MM/DD/YYYY) | Height

Address

Marital Status
◯ Single ◯ Married
◯ Divorced
◯ Widowed ◯ Separated

Weight

City | State | ZIP/Postal Code

Home Phone | Cell Phone | Spouse's Name | Spouse's Birth Date

E-Mail Address

As a Courtesy, we utilize TEXT MESSAGE or EMAIL for appointment reminders. Please choose one:

◯ Text Message (Phone Number) _____ Carrier: _____ ◯ Email address listed above

Initials_____ I grant permission to be called, emailed, or receive text messages to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in the office.

Emergency Contact | Relationship & Phone

Your Occupation | Your Employer

Primary Physician

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: 08/072017

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? _____

Driver's License #_____

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

Describe details of the accident / incident: _____

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

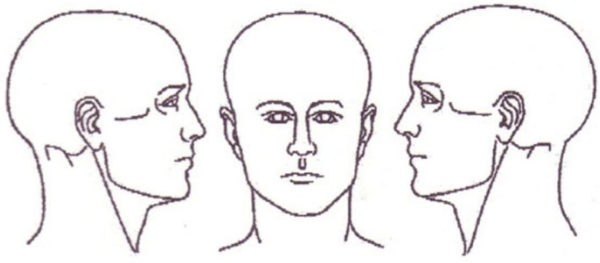
If yes, please list in detail: _____

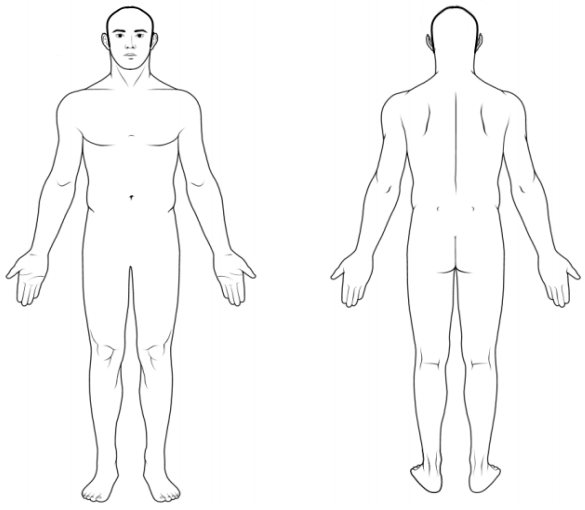
Check Symptoms Apparent SINCE Accident:

◯ 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:





Modified: 08/08/2017

ACTIVITIES OF DAILY LIVING

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

If yes, list activities you are UNABLE to do: _____

Activities that are painful and 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 _____ ◯ Recreation _____

◯ Sleeping _____ ◯ Personal care _____ ◯ Traveling _____ ◯ Work _____

◯ Lifting _____ ◯ Walking _____ ◯ Standing _____ ◯ Other _____

FREQUENCY OF PAIN

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

PAST MEDICAL HISTORY AND FAMILY HEALTH HISTORY

Please note dates of each:

◯ Mental Illness ◯ Diabetes ◯ Hepatitis ◯ HIV+ ◯ AIDS ◯ Herpes

◯ Heart Disease ◯ Asthma ◯ Allergies ◯ Stroke ◯ Arthritis ◯ Cancer

◯ Chronic Fatigue ◯ Gall Stones ◯ Venereal Disease ◯ Osteoporosis ◯ Seizures ◯ Parasites

◯ Mononucleosis ◯ Kidney Stones ◯ Thyroid Problems ◯ Rheumatic Fever ◯ Ulcers

◯ High Blood Pressure ◯ Other _____

Are you Pregnant? Y / N Estimated Due Date: _____ Any complications? _____

Prior illnesses, operations, injuries or treatments (including significant dental work): _____

_____

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

Medications/Supplements: _____

Social History: Tobacco Use: Y / N Per: _____ Caffeine: Y / N Per: _____ Alcohol: Y / N Per:_____

Occupational Stress (Chemical, physical, psychological):_____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

_____ _____

Patient/Guardian Signature Date (MM/DD/YYYY)

If the patient is a minor child, print child's full name: _____

Modified: 08/08/2017