**If you have already retained an attorney for this case, please inform us prior to filling out this paperwork.**

**If, at any point during your care, you decide that you need an attorney, please discuss it with the doctor prior to retaining one.**

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_

H. Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_W. Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address\_\_\_\_\_\_\_\_\_\_\_\_lollie\_429@yahoo.com\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by:\_\_\_\_Tanya King\_\_\_\_\_\_\_\_\_\_\_

Sex M F Marital Status M S D W Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Have you received any other treatment for your injuries from this accident? ( ) NO ( ) YES**

If YES, circle treatment(s) received:

Anti-inflammatory Meds Pain Meds Muscle Relaxers

Trigger Point Injections Cortisone Injections Massage

Physical Therapy Chiropractic Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Since the Motor Vehicle Collision, have you experienced any of the following:**
2. Loss of Range of Motion: yes/no
3. What body part(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Visual Disturbance: yes/no (please explain):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Dizziness: yes/no How often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Anxiety: yes/no How often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Depression: yes/no How often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Difficulty Sleeping: yes/no How often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. **Past Health History:**
10. **Previous illnesses you’ve had in your life:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Previous Injury or Trauma: \_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever broken any bones? Which?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Allergies: \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Medications:**

Medication Reason for taking

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Surgeries:**

Date Type of Surgery

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Females/ Pregnancies and outcomes:**

Pregnancies and delivery dates *(live birth/still birth/misc/term)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. **Family Health History:**

Associated health problems of relatives: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Deaths *due to illness* in immediate family: Age at death

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. **Social and Occupational History:**
2. **Job description:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **Work schedule:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. **Recreational activities:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. **Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to **Dr. Matthew Robbins** for services performed.

Patient or Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PERSONAL INJURY INFORMATION

FULL NAME PHONE

ADDRESS CITY ST ZIP AGE BIRTH DATE SEX **M F** SS#

DATE OF ACCIDENT TIME OF DAY AM/PM

EMERGENCY CONTACT PHONE #

ADDRESS RELATIONSHIP

*YOUR AUTO INSURANCE INFORMATION:*

Name of Insured Policy #

Insurance Company Phone #

“Med Pay” Claim # Adjuster/Phone#

*THE AUTO INSURANCE OF THE OTHER PARTY INVOLVED:*

Name of Insured Policy # \_\_\_\_\_\_

Insurance Company Phone #

Adjuster/Phone# Claim #

*YOUR HEALTH INSURANCE INFORMATION:*

Name of Insured Relationship to you

Insurance Company

Group Plan # Phone #

Insured ID# ***Please give us a copy of your ID card.***

*ATTORNEY INFORMATION (IF APPLICABLE):*

Attorney Name Phone #

Address City St Zip

**\*\*IF YOU RETAIN AN ATTORNEY AT A LATER DATE, PLEASE NOTIFY US IMMEDIATELY\*\***

**PLEASE ALLOW US TO MAKE A COPY OF THE FOLLOWING:**

**DRIVER’S LICENSE OR PICTURE ID**

**HEALTH INSURANCE CARD**

**INCIDENT REPORT**

**REVIEW OF SYSTEMS**

**Have you ever been diagnosed with any Pulmonary (Lung) Disorders  No  Yes** (check below)

|  |  |  |  |
| --- | --- | --- | --- |
| * Asthma/difficulty breathing | * COPD | * Emphysema | * Other\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Have you ever been diagnosed with any Cardiovascular (Heart) Disorders  No  Yes** (check below)

|  |  |  |
| --- | --- | --- |
| * Heart surgeries | * Congestive heart failure | * Murmurs or valvular disease |
| * Heart attacks | * Heart disease/problems | * hypertension |
| * Pacemaker | * Angina/chest pain | * Irregular heartbeat |
| * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

**Have you ever been diagnosed with any Neurological (Nerve) Disorders  No  Yes** (check below)

|  |  |
| --- | --- |
| * Visual changes/loss of vision | * One-sided weakness of face or body |
| * History of seizures | * 1-sided decreased feeling in face or body |
| * Headaches | * Memory loss |
| * Tremors | * Vertigo |
| * Loss of sense of smell | * Strokes/TIAs |
| * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

**Have you ever been diagnosed with any Endocrine (Gland) Disorders  No  Yes** (check below)

|  |  |  |
| --- | --- | --- |
|  Thyroid disease | * Hormone replacement therapy | * Injectable steroid replacements |

**Have you ever been diagnosed with any Renal (Kidney) Disorders  No  Yes** (check below)

|  |  |  |  |
| --- | --- | --- | --- |
| * Renal calculi/stones | * Hematuria | * Incontinence | * Bladder infections |
| * Difficulty urinating | * Kidney disease | * Dialysis | * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Have you ever been diagnosed with any Gastroenterological (Intestinal) Disorders  No  Yes** (check below)

|  |  |
| --- | --- |
| * Nausea | * Difficulty swallowing |
| * Ulcerative disease | * Frequent abdominal pain |
| * Hiatal hernia | * Constipation |
| * Pancreatic disease | * Irritable bowel/colitis |
| * Hepatitis or liver disease | * Bloody or black tarry stools |
| * Vomiting blood | * Bowel incontinence |
| * Gastroesophageal reflux/heartburn | * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Have you ever been diagnosed with any Hematological (Blood) Disorders  No  Yes** (check below)

|  |  |
| --- | --- |
| * Anemia | * Regular anti-inflammatory use |
| * HIV positive | * Abnormal bleeding/bruising |
| * Sickle-cell anemia | * Enlarged lymph nodes |
| * Hemophilia | * Hyper coagulation/deep vein thrombosis |
| * Anticoagulant therapy | * Regular aspirin use |
| * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

**Have you ever been diagnosed with any Dermatological (Skin) Disorders  No  Yes** (check below)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Significant burns | * Significant rashes | * Skin grafts | * Psoriatic disorders | * Other\_\_\_\_\_\_ |

**Have you ever been diagnosed with any Musculoskeletal (Bone) Disorders  No  Yes** (check below)

|  |  |  |  |
| --- | --- | --- | --- |
| * Rheumatoid Arthritis | * Gout | * Osteoarthritis | * Broken bones |
| * Spinal fracture | * Spinal surgery | * Joint surgery | * Arthritis (unknown type) | |
| * Scoliosis | * Metal implants | * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

**Have you ever been diagnosed with any Psychological (mental) Disorders  No  Yes** (check below)

|  |  |  |
| --- | --- | --- |
| * Psychiatric diagnosis | * Depression | * Suicidal ideations |
| * Bipolar Disorder | * Homicidal ideations | * Schizophrenia |
| * Psychiatric hospitalizations | * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |