Personal Injury Patient Information

Name: _____ Date: _____

Birthdate: _____ /_____ /_____ Age: _____ Gender: _____ Height: _____ Weight: _____

Phone: _____ Email: _____

Address: _____ City: _____ Zip code: _____

Emergency contact/relationship: _____ Phone: _____

Date of accident: _____ /_____ /_____ Time: _____ am/pm Damage of your car: $_____

Year & model of your car: _____ Year & model of the other car: _____

Where were you seated? _____ Were you wearing a seatbelt? ☐Yes | ☐No

Speed of your car: _____ mph Other car: _____ mph City/State of accident: _____

Type of collision: ☐Head-on ☐Broad-side ☐Front impact ☐Rear-end car in front ☐Rear impact

In your own words, please describe the accident: _____

_____

At the time of the accident, what parts of your head or body hit which parts on the inside of your car?

_____

Describe how you felt immediately after the accident: _____

_____

Later that day: _____

The next day: _____

Did you have any bleeding cuts? ☐Yes | ☐No If yes, where? _____

Did you receive any bruises? ☐Yes | ☐No If yes, where? _____

Did you seek medical help immediately after? ☐Yes | ☐No Taken by ambulance? ☐Yes | ☐No

If yes, please explain: _____

Name of doctor/hospital: _____ Last date of treatment: _____

Current medications: _____

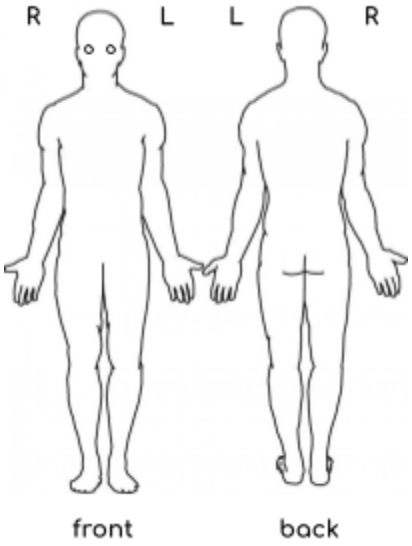
Have you missed time from work? ☐Yes | ☐No If yes, how many days? _____

Occupation: _____ Employer: _____

Are you pregnant? ☐Yes | ☐No If yes, how far along? _____ weeks Due date: ____ /____ /____

Have you ever seen a chiropractor? ☐Yes | ☐No If yes, how long ago? _____

Please mark on the picture where you have pain, and rate your pain on a scale of 1 to 10 (extreme): _____



For Doctor's use only

Please circle the current symptoms and primary complaints apparent since the accident:

Neck pain	Arm R / L	Elbow R / L	Light sensitivity	Facial pain
Upper back pain	Hand R / L	Headache	Pain behind eyes	Clicking jaw
Mid back pain	Hip R / L	Fainting	Sleeping problems	Numb hands
Low back pain	Thigh R / L	Dizziness	Shortness of breath	Numb toes
Pelvis	Knee R / L	Fatigue	Loss of memory	Cold hands
Shoulder R / L	Leg R / L	Chest pain	Loss of taste	Cold feet
Wrist R / L	Foot R / L	Diarrhea	Loss of smell	Cold sweats

Please check the symptoms that you have had as a result of the accident:

Genitourinary: ◯ Excessive urination ◯ Bladder issues ◯ Scanty urination ◯ Painful urination

Gastrointestinal: ◯ Poor appetite ◯ Diarrhea ◯ Hemorrhoids ◯ Excessive hunger
◯ Gallbladder issues ◯ Constipation ◯ Nausea ◯ Excessive thirst
◯ Difficulty swallowing ◯ Black stool ◯ Vomiting ◯ Abdominal pain
◯ Difficulty chewing ◯ Bloody stool ◯ Liver trouble ◯ Weight issues

Nervous system: ◯ Numbness ◯ Fainting ◯ Headaches ◯ Forgetfulness
◯ Loss of feeling ◯ Dizziness ◯ Depression ◯ Muscle jerking
◯ Paralysis ◯ Confusion ◯ Anxiety ◯ Convulsions

Cardiovascular: ◯ High blood pressure ◯ Persistent cough ◯ Rapid heartbeat ◯ Varicose veins
◯ Coughing blood ◯ Heart problems ◯ Pain over heart ◯ Chest pain
◯ Coughing phlegm ◯ Lung problems ◯ Short of breath ◯ Other: _____

Eyes, ears, nose, & throat:
◯ Eye strain ◯ Ear pain ◯ Nose bleeding ◯ Dental problems
◯ Eye inflammation ◯ Ear noises ◯ Nose discharge ◯ Sore gums
◯ Vision problems ◯ Hearing loss ◯ Nose pain ◯ Sore mouth
◯ Difficulty breathing ◯ Speech issues ◯ Hoarseness ◯ Sore throat

Health History

Please circle any conditions that you have, or have had previously.

AIDS/HIV	Depression	Hernia/herniated disk
Anemia	Dizziness	Osteoporosis
Anorexia/Bulimia	Epilepsy	Seizures
Anxiety	Fractures	Stroke
Arthritis	Headaches	Suicide attempts
Cancer	Heart attack	Tumors

Please list and date any previous injuries, surgeries, and/or auto accidents:

_____

_____

Activities of Daily Living Assessment

Section 1: Pain Intensity

◯ I can tolerate the pain without painkillers
◯ The pain is bad, but I manage without painkillers
◯ Painkillers give no relief from pain, I don't use them
◯ Painkillers give very little relief from pain
◯ Painkillers give moderate relief from pain
◯ Painkillers give complete relief from pain

Section 2: Personal Care

◯ It causes me no pain to take care of myself
◯ I need some help, but I can mostly manage
◯ I'm careful taking care of myself as it's painful
◯ It causes extra pain to take care of myself
◯ I need help daily in most aspects of care
◯ I don't get dressed or wash up, I stay in bed

Section 3: Lifting

◯ I can lift heavy weights without extra pain
◯ I can lift heavy weights, but it causes me pain
◯ I can lift heavy weights if conveniently placed
◯ I can lift light to medium weights
◯ I can only lift very light weights
◯ I cannot lift anything at all

Section 4: Walking

◯ I can walk any distance without pain
◯ I can't walk more than 1 mile without pain
◯ I can't walk more than ½ mile without pain
◯ I can't walk more than ¼ mile without pain
◯ I can only walk with a cane or crutches
◯ I'm in bed most of the time

Section 5: Sitting

◯ I can sit in any chair as long as desired
◯ I can only sit in my favorite chair as long desired
◯ I can't sit for more than 1 hour without pain
◯ I can't sit for more than ½ hour without pain
◯ I can't sit for more than 10 minutes
◯ I can't sit at all without pain

Section 6: Standing

◯ I can stand as long as desired without pain
◯ I can stand as long as desired, but it causes pain
◯ I can't stand for more than 1 hour without pain
◯ I can't stand for more than ½ hour
◯ I can't stand for more than 10 minutes
◯ I can't stand at all without pain

Section 7: Sleeping

◯ Pain doesn't prevent me from sleeping
◯ I can only sleep by taking medication
◯ Even with medication, I sleep less than 2 hours
◯ With medication, I sleep less than 4 hours
◯ With medication, I sleep less than 6 hours
◯ Pain prevents me from sleeping at all

Section 8: Social Life

◯ My social life is normal and causes no extra pain
◯ My social life is normal, but causes some extra pain
◯ Pain only limits my more energetic interests
◯ Pain restricts my social life, I go out less
◯ Pain has restricted my social life to home
◯ I have no social life due to pain

Section 9: Traveling

◯ I can travel anywhere without extra pain
◯ I can travel anywhere, but it causes extra pain
◯ I can't manage journeys more than 2 hours
◯ Pain restricts me to trips less than 1 hour
◯ Pain restricts me to trips less than ½ hour
◯ Pain prevents traveling except to the doctor

Third Party Agreement

1) If you retain an attorney, you and the attorney are required to sign a lien agreeing to pay your medical bills in full when a settlement is reached. If at any time during treatment your attorney no longer represents your case, you will then be financially responsible for your balance at our office.

2)If you do not wish to retain an attorney, you may pay our out-of-pocket price of $105.00 for the initial exam and $45.00 for follow-ups, or $85 for the initial exam and $40/$35 for follow-ups for those in high school or younger/those 65 years of age and over. You are agreeing to pay at the time service is rendered. There is a $15 missed appointment fee. If your account has an outstanding balance that exceeds 30 days without contact from you, it will be forwarded to a collections agency. X-RAYS ARE AN ADDITIONAL FEE.

Signature: _____ Date: _____

Informed Consent to Chiropractic Treatment and Care

I hereby request and consent to the performance of procedures within the scope of the practice of chiropractic, including, but not limited to chiropractic adjustments, various modes of physical therapy (including Pulsed Electromagnetic Field Therapy), and diagnostic x-rays for myself (or the patient for whom I am legally responsible) by Dr. Toy and his associates. I understand that, as in the practice of medicine and other clinical therapies, there are some risks to treatment, including, but not limited to temporary aggravation of my condition or soreness. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on their judgment during the course of my treatment regarding what they feel will be most profitable and effective, with my best interest in mind.

Signature: _____ Date: _____

Pregnancy Release (if applicable)

To the best of my knowledge, I am not pregnant. The doctor has my permission to perform an x-ray evaluation which can be hazardous to an unborn child. Date of last menstrual period: _____