

Today's Date: ___/___/___

Patient Information



Patient Information - Section 1

Patient Name: _____ Male Female
 Address: _____
 City: _____ State: _____ Zip: _____ Country: _____
 Birth Date: ___/___/___ Social Security Number: _____-_____-_____
 Home #: () _____ Cellular #: () _____
 Work #: () _____ Extension _____ Fax #: () _____
 E-Mail Address: _____
 Single Married Divorced Widowed Name of Spouse: _____
 Number of Kids: _____ Name of Kids: _____
 Employer: _____ Occupation: _____
 Employers Address: _____ City: _____ State: _____ Zip: _____
 Emergency Contact: _____ Phone Number _____
 Reason for Consulting our office: _____
 Referred By: _____ Do you have health insurance? Yes No
 Can we inform your medical doctor about your care in our office? Yes No
 Your current Medical Doctor's first and last name: _____
 Is today's problem caused by: Auto Accident Workman's Compensation Other Accident / Fall

Accident Information - Section 2 (If not any kind of accident please skip to Section 3)

1. Date of the accident: _____ 2. Time of accident: _____ am / pm
 What kind of vehicle were you in? Car SUV Pick up Van Other: _____
 Vehicle Size: Full Size Mid Size Compact Other: _____
 3. How many vehicles were involved? _____
 What kind of vehicle was involved? Car SUV Pick up Van Other: _____
 Vehicle Size: Full Size Mid Size Compact Other: _____
 4. What was the estimated damage of your vehicle? Totaled Unknown Other _____
 5. What city and state were you in? _____
 6. What street or intersection were you on when the accident occurred? _____
 7. What direction were you traveling? _____
 8. Did you vehicle hit anything after the accident? If yes please describe: _____
 9. What was your location in the vehicle? Driver Front Passenger Rear Passenger
 Rear Passenger location: Driver Side Middle Passenger Side
 10. Did you know the accident was coming? Yes No
 11. How fast was your vehicle going? _____ MPH Slowing Steady pace Speeding Up Stopped/Parked
 12. If another vehicle was involved, how fast was it going? _____ MPH Slowing Steady pace Speeding Up
 13. Were you struck from: Behind Front Left Side Right Side
 14. During the crash, what happen to you vehicle? (check all that apply)
 Kept going straight Spun around Kept going straight hitting a car in front
 Spun around and hit a stationary object Was hit by another vehicle Hit a stationary object
 Other: _____
 15. Did you lose consciousness during the accident? Yes No
 16. How was your head positioned during the accident? _____
 17. How was your torso positioned during the accident? _____
 18. How were your hands positioned during the accident? _____
 19. Did your head hit anything during the accident? Yes No If yes, please explain: _____



20. Did your face hit anything during the accident? Yes No If yes, please explain: _____
21. Did your shoulders hit anything during the accident? Yes No If yes, please explain: _____
22. Did your neck hit anything during the accident? Yes No If yes, please explain: _____
23. Did your chest hit anything during the accident? Yes No If yes, please explain: _____
24. Did your hips hit anything during the accident? Yes No If yes, please explain: _____
25. Did your knees hit anything during the accident? Yes No If yes, please explain: _____
26. Did your feet hit anything during the accident? Yes No If yes, please explain: _____
27. What kind of headrest was in your vehicle?
 Movable fixed headrest Nonmovable fixed headrest No headrest
28. Where was the headrest positioned on your head? _____
29. Did you have your seat belt on during the accident? Yes No If yes, please select type:
 Shoulder-Lap Belt Shoulder Belt Lap Belt
30. Did you slide out of your seatbelt during the accident? Yes No
31. What was the damage to your vehicle? (Check all that apply)
 Windshield Rear Bumper Mirror Steering Wheel Front Bumper
 Knee Bolster Dashboard Trunk Back Right Door Seat Frame
 Front Left Door Completely Totaled Side Window Front Right Door Rear Window
 Back Left Door Other: _____
32. Choose items that dented inward: Floorboards Side Door Dashboard None
33. Choose the doors that would not open as a result of the accident:
 Front Left Rear Left Front Right Rear Right All doors opened
34. Did you go to the hospital? Yes No If No, skip questions 35-40.
35. How did you get to the hospital? _____
36. What hospital did you go to? _____
37. Were you hospitalized over night? Yes No
38. Circle what you were prescribed at the hospital:
 Pain Medications Muscle Relaxors Neck Brace Other: _____
39. Did you receive any stitches for any cuts at the hospital? Yes No
40. Were any X-Rays taken at the hospital? Yes No If yes, please explain: _____

General Information - Section 3

41. What are your goals with spinal care? _____

42. What things interest you or would you like to learn more about? - Please check those items that apply
 Nutrition Family Health
 Exercise Wellness
 General Health Sports Enhancement
 Immune Function Improvement

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare 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 this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Fisher Family Chiropractic extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors at Fisher Family Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment, I certify that the above information is true and correct.

 Signature / /
Date