Ponte Vedra Beach Chiropractic, Inc.
814 A1A N, Ste. 102, Ponte Vedra Beach, FL 32082 www.PonteVedraBeachChiro.com

NEW PATIENT INFORMATION

Patient's Name___________________________________ Date ________________

Address ______________________________ City ______________ Zip Code _______

Home or Cell Phone _______________________ Work Phone _____________________

E-mail ________________________________ Date of Accident __________________

Employer ______________________________ Job Title _____________________

Date of Birth _________ Age____ Gender ❑ Male ❑ Female Handedness? R L

Weight_____ Height ______ Marital Status S M W D Smoker Y N (Former)

Ethnicity: ❑ Hispanic __ Latino ❑ Non-Hispanic / Non-Latino

Race: ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other

Person responsible for this account______________________ Relation_______________

Health Insurance ________________________ *Please provide your health insurance card.*

Auto Insurance _________________________ *Please provide your auto insurance card.*

Claim # ______________________ Driver's License # __________________________

In case of emergency, whom should we contact?___________________________________

Phone #____

Family physician______________________ Phone #__________________________

Address____________________________ City____________ Zip Code___________

Did you consult with any healthcare provider within the first 14 days after the accident, if so who?

Hospital__________________________ Medical Doctor ________________________

Chiropractor_______________________ Physical Therapist _____________________

Medications prescribed: ____

Allergies to medications: ____

Have you been in any previous accidents of any kind within the past 5 years? Y N

Have you ever been treated for neck pain, back pain or headaches prior to this accident? Y N

If yes, please explain ____

Previous surgeries? ____

☐ May be pregnant ☐ Yes, I am definitely pregnant ☐ No, I am definitely not pregnant at this time

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ACCIDENT QUESTIONNAIRE

Patient's Name________________________________ Date of accident __________Today's Date_____________

CIRCLE ALL THAT APPLIES

Driver Front Passenger
Back Passenger Driver's side
Back Passenger Right Side
Back Passenger Middle

Alone or With Others

Aware or Unaware of impending accident

Description of Accident: ______________________

____

____

____

Patient Vehicle: Compact Car Mid-Sized Car
Full Sized Car Sport Utility Vehicle Pick-up Truck
Bus Other __________________________________

Other Vehicle: Compact Car Mid-Sized Car
Full Sized Car Sport Utility Vehicle Pick-up Truck
Bus Other __________________________________

Speed of Patient's Vehicle:
Slow Moderate Fast Stopped

Speed of Other Vehicle:
Slow Moderate Fast Stopped

Type of restraint: Lap Belt Shoulder Belt

Did Airbags deploy: Yes No

Damage to patient's vehicle: Complete
Extensive Minimal Moderate

Where did the accident happen: Highway
City Road Neighborhood Road Intersection
On / Off Ramp Making RT Turn Making LT Turn

How was the patient's vehicle hit: Head-on
Hit on Left Front Hit on Right Front
Hit on Left Rear Hit on Right Rear
Rear-Ended Other _________________

Head position at time of impact: Leaning Forward
Looking Straight Turned Left Turned Right

Did any portion of your body hit an object in the vehicle? Yes No If Yes, please explain

____

After the accident, what did you do? Go Home
Go About Your Business Hospital by Ambulance
Driven to Hospital Drove Self to Hospital
Other _______________________________________

Hospital or Medical Facility: ___________________

____

Received: X-rays MRI CAT Scan Stitches
Other _______________________________________
Medications _________________________________

Is there any other information that the doctor should know about your accident? ________________________

____

____

____

____

INJURIES & SYMPTOMS

Patient's Name_____________________________________

CIRCLE ALL YOUR INJURIES / COMPLIANTS

1. Please list any **CUTS, LACERATIONS OR BRUISING**:
   ____

Seat belt bruising: Yes No   Injury from the air bag: Yes No

2. **HEAD:** *(now or at the time of the accident)*

Were you knocked out or unconscious   Headaches   Face pain   Dizziness   Room spins

Balance problems   Difficulty walking   Visual Disturbances, blurry or double vision   Sleep Difficulty

Very tired or fatigued   Nausea / Vomiting   Flashbacks to accident   Memory problems   Confusion

Difficulty speaking   Problems to read or write   Hearing problems   Change in sense of smell or taste

3. **JAW:** Jaw pain   Jaw clicking   Pain while chewing   Pain while talking

4. **NECK:** Neck pain   Neck pain that causes headaches

Neck pain that travels into the RIGHT: Shoulder Arm Hand Upper Back *(Circle all that apply)*

Neck pain that travels into the LEFT: Shoulder Arm Hand Upper Back *(Circle all that apply)*

5. **SHOULDER:** Shoulder pain LEFT RIGHT BOTH

6. **UPPER EXTREMITY:** Upper arm pain LEFT RIGHT BOTH

Elbow pain LEFT RIGHT BOTH   Forearm pain LEFT RIGHT BOTH

Wrist pain LEFT RIGHT BOTH   Hand pain LEFT RIGHT BOTH

7. **BACK:** Upper back pain   Upper back pain into the neck   Mid-back pain

Mid-back pain into the RIGHT rib cage   Mid-back pain into the LEFT rib cage

8. **LOWER BACK:** Lower back pain LEFT RIGHT BOTH

Lower back pain that travels into the RIGHT: hip buttock thigh knee leg foot toes *(Circle all that apply)*

Lower back pain that travels into the LEFT: hip buttock thigh knee leg foot toes *(Circle all that apply)*

9. **HIP:** Hip pain LEFT RIGHT BOTH

Hip pain that travels into RIGHT: buttock thigh knee leg foot toes *(Circle all that apply)*

Hip pain that travels into LEFT: buttock thigh knee leg foot toes *(Circle all that apply)*

10. **LOWER EXTREMITY:** Thigh pain LT RT BOTH   Knee pain LT RT BOTH

Leg pain LT RT BOTH   Ankle pain LT RT BOTH   Foot pain LT RT BOTH

11. **CHEST PAIN**   12. **STOMACH PAIN**

Is there any other information that the doctor should know about your injuries or complaints?

____

____

Patient Signature: ____   Date: ____________________

Health History

Who is your primary care physician? (doctor and/or practice) ______________________

CHECK ANY OF THE FOLLOWING PAST MEDICAL PROBLEMS YOU HAVE HAD:

	Now	Past		Now	Past		Now	Past
Diabetes			Thyroid Disease			Osteoporosis		
Ulcers			Goiter			Polio		
Gastric Reflux/ GERD			Kidney Disease			Fractures		
Colitis / IBD			Pneumonia			Multiple Sclerosis		
Heart Disease			Tuberculosis			Parkinson's		
Congestive Heart Disease			Influenza			Prostate Problems		
Blood Clots (DVT)			Asthma			Immune Disorder		
Peripheral Vascular Disease			Emphysema			Migraine Headaches		
Stroke			COPD			Seizure Disorder		
Pacemaker			Bronchitis			AIDS/HIV		
High Cholesterol			Liver Disease			Chemical Dependency		
High Cholesterol			Osteoarthritis			Mental Disorders		
Bleeding Disorder			Rheumatoid Arthritis			Depression		
Anemia			Gout			Alcoholism		
Cancer: ❑ Now ❑ Past	Type: Bone	Colon	Breast	Prostate	Stomach	Brain	Lung	Skin Other:

CHECK ANY OF THE FOLLOWING DISEASES / SYMPTOMS YOU HAVE HAD IN THE PAST SIX MONTHS:

GENERAL
- ❑ Fatigue
- ❑ Fever/Chills
- ❑ Unexpected weight loss
- ❑ Unexpected weight gain

EYES
- ❑ Corrective lens
- ❑ Eye pain
- ❑ Visual problems
- ❑ Eye redness

HEMATOLOGIC / LYMPH
- ❑ Easy bleeding
- ❑ Bruising
- ❑ Swollen Glands

SKIN
- ❑ Skin Changes
- ❑ Poor skin healing
- ❑ Rash
- ❑ Itching

ENDOCRINE
- ❑ Heat/Cold intolerance
- ❑ Hot flashes
- ❑ Thinning/Losing hair

MUSCULO-SKELETAL
- ❑ Neck Pain
- ❑ Back Pain
- ❑ Limb Pain
- ❑ Headaches
- ❑ Joint Pain / Stiffness/Swelling
- ❑ General Stiffness

GASTROINTESTINAL
- ❑ Heartburn/GERD/reflux
- ❑ Black/Bloody Stool
- ❑ Abdominal Cramps/Pain
- ❑ Constipation
- ❑ Diarrhea
- ❑ Nausea / Vomiting

CARDIOVASCULAR
- ❑ Chest pain
- ❑ Palpitations
- ❑ Faintness
- ❑ Ankle swelling
- ❑ Pain upon exertion
- ❑ Leg pain with exercise

EAR/NOSE/THROAT
- ❑ Frequent sore throat
- ❑ Hearing problems
- ❑ Sinus pain
- ❑ Ear pain
- ❑ Ringing in ears
- ❑ Vertigo

GENITOURINARY
- ❑ Bladder Trouble
- ❑ Painful Urination
- ❑ Prostate Problems
- ❑ Sexual Dysfunction
- ❑ Discharge

NERVOUS SYSTEM
- ❑ Balance Problems
- ❑ Loss of strength
- ❑ Paralysis
- ❑ Dizziness
- ❑ Tremors

RESPIRATION
- ❑ Shortness of breath
- ❑ Cough
- ❑ Wheezing
- ❑ Congestion
- ❑ Difficulty breathing

PSYCHIATRIC
- ❑ Loss of Memory
- ❑ Difficulty sleeping
- ❑ Anxiety
- ❑ Depression

FEMALES ONLY
- ❑ Menstrual problems
- ❑ Breast pain/lumps
- ❑ Pelvic pain

Last period? __________

Pregnant? ❑ Yes ❑ No

Medications (unrelated to accident): ____

Under medical care? ❑ Yes ❑ No Type: _________________ On a special diet? ❑ Yes ❑ No Type: ___________

Do you exercise: ❑ Yes ❑ No How often? _______ Work: ❑ Desk job ❑ Moderate activity ❑ Heavy Labor

Is there a family history of any of the following conditions? (P = Parents, G = Grandparents, S = Siblings)

❑ Heart Disease ________ ❑ Diabetes ________ ❑ Autoimmune Disease ________ Other _____________________________

❑ Cancer ________ ❑ Arthritis ________ ❑ Blood Disorder or Anemia _______

What is your daily/weekly intake of the following: Caffeine ______ cups/day Alcohol drinks/week ________

Cigarettes ____ packs/day Ever a Smoker Yes / No / Former

- **I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health**

SIGNATURE (X) ____ **DATE** _________________