Ponte Vedra Beach Chiropractic, Inc.
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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____________

ACCIDENT QUESTIONNAIRE

Patient's Name_______________________________ Date of accident __________Today's Date____________

Description of accident: ____
____
____
____
____

Injured Areas: Areas where you felt immediate pain. *(Check all that apply)*

__ head | __ neck R L | __ upper back R L | __ right shoulder
__ right arm | __ right forearm | __ right wrist / hand | __ left shoulder
__ left arm | __ left forearm | __ left wrist / hand | __ mid-back R L
__ low back R L | __ right pelvis | __ right thigh | __ right leg
__ right ankle | __ right foot | __ left pelvis | __ left thigh
__ left leg | __ left ankle | __ left foot

Did you feel? *(Check all that apply)*

__ disoriented | __ stunned | __ frightened
__ lost consciousness | __ loss of memory | __ fuzzy / confused
__ blurred vision | __ nausea | __ light headed

Other injuries: *(Check all that apply)*

__ bruising on the: __ chest __ arms R L __ legs R L __ head __ face
__ cuts on the: __ chest __ arms R L __ legs R L __ head __ face

Pain was felt: __ immediately __ 1-3 days later __ 1-2 weeks later __ 2-4 weeks later
__ other ___________________________

After the accident, did you
( ) go home ( ) go about your business ( ) go to hospital, name of hospital____________________

If taken to the hospital, how?
( ) Ambulance ( ) Driven by relative/friend ( ) Drove self
( ) Did not go to the hospital ( ) Home first and later taken or drove to the hospital
( ) walked to hospital ( ) hospital next day ( ) hospital days later

What was done in the emergency room or hospital? *(Check all that apply)*
( ) Examination ( ) Stitches ( ) X-Rays ( ) MRI ( ) CAT Scan
( ) Cervical collar ( ) Complete bed rest ( ) Medication ( ) Physiotherapy
( ) Other:____

Were you admitted into the hospital? ( ) Yes ( ) No
If Yes, how long? ______________________________

When did you first consult a physician?
( ) Same day ( ) Following day ( ) Within a few days
( ) Other:____

Who did you consult (please write name):____
( ) Family physician ( ) Chiropractor ( ) Orthopedist ( ) Osteopath
( ) Neurologist ( ) Neurosurgeon ( ) Pain Mngmt. ( ) Other:________

What did the doctor do? *(Check all that apply)*
( ) Chiropractic adjustment ( ) Examination ( ) Injections ( ) X-Rays
( ) Traction ( ) Prescriptions ( ) Physiotherapy
( ) Other:____

How long were you under this doctor's care?________ Are you still under their care? ( ) Yes ( ) No
Frequency of visits now?_______________________

Did the doctor refer you to or have you seen any other physicians? ( ) Yes ( ) No
If yes, please explain:____

Past History:
Have you ever been in any previous accidents of any kind within the past 5 years? ( ) Yes ( ) No
If yes, please give dates and details:____
____

Have you ever been treated for neck pain, back pain, or headaches by any other physicians prior to this accident?
( ) Yes ( ) No If yes, please explain:____
____

Have you had any previous surgery or any other condition the doctor should know about? ( ) Yes ( ) No
If yes, please explain:____
____

Is there any other information that the doctor should know about your injuries or accident that was not covered by this form? If so please explain below. ____
____
____

Allergies:____

Are you currently taking any medications:
____

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

Patient's Name:____ Date:_______________________

Patient's Signature:____

Health History

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 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
- ❑ Always Tired / 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** ______________