



Gonstead Family Chiropractic

NEW PATIENT INTAKE FORM -- Personal Injury

PATIENT INFORMATION

CONFIDENTIAL

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We will be happy to help.

Name _____ Date ____/____/____ S/S ____ - ____ - ____
First MI Last

Address _____ City _____ State ____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Birth Date ____/____/____ Height _____ Weight _____ e-mail address: _____

Sex: Female Male Status: Minor Married Single Other

Your Employer _____ Occupation _____

Business Address _____ City _____ State ____ Zip _____

Spouse/ Parent's Name _____ Phone _____

Who may we thank for referring you to us? _____

Person to contact in case of an emergency _____ Phone _____

INSURANCE CO. _____ **Policy #** _____

Name on Policy (if not self) _____

Responsible Party's Name _____ Agent's name _____

Address _____

ATTORNEY _____ **Phone** _____

Address _____

HEALTH HISTORY

Please check the following symptoms you have noticed **SINCE THE ACCIDENT** (○) or **BEFORE THE ACCIDENT** (☐):

- | | | |
|--|---|--|
| <input type="checkbox"/> <input type="checkbox"/> Headaches | <input type="checkbox"/> <input type="checkbox"/> Irritability | <input type="checkbox"/> <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> <input type="checkbox"/> Neck Pain | <input type="checkbox"/> <input type="checkbox"/> Mood Swings | <input type="checkbox"/> <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> <input type="checkbox"/> Upset Stomach |
| <input type="checkbox"/> <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> <input type="checkbox"/> Fatigue | <input type="checkbox"/> <input type="checkbox"/> Constipation |
| <input type="checkbox"/> <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> <input type="checkbox"/> Depression | <input type="checkbox"/> <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> <input type="checkbox"/> Arm Pain | <input type="checkbox"/> <input type="checkbox"/> Chest Pain | <input type="checkbox"/> <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> <input type="checkbox"/> Leg Pain | <input type="checkbox"/> <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> <input type="checkbox"/> Fever | <input type="checkbox"/> <input type="checkbox"/> Allergies |
| <input type="checkbox"/> <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> <input type="checkbox"/> Fainting | <input type="checkbox"/> <input type="checkbox"/> Menstrual Pain |
| <input type="checkbox"/> <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> <input type="checkbox"/> Dizziness | <input type="checkbox"/> <input type="checkbox"/> Menstrual Irregularity |
| <input type="checkbox"/> <input type="checkbox"/> Cold Hands | <input type="checkbox"/> <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> <input type="checkbox"/> Cold Feet | <input type="checkbox"/> <input type="checkbox"/> Light Sensitivity with Eyes | <input type="checkbox"/> <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> <input type="checkbox"/> Nervousness | <input type="checkbox"/> <input type="checkbox"/> Ringing/ Bumping in Ears | <input type="checkbox"/> <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> <input type="checkbox"/> Tension | <input type="checkbox"/> <input type="checkbox"/> Loss of Memory | |

Have **YOU** (○) or **A FAMILY MEMBER** (☐) ever been diagnosed with any of the following conditions:

- | | | |
|---|---|---|
| <input type="checkbox"/> <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> <input type="checkbox"/> Heart Disease | <input type="checkbox"/> <input type="checkbox"/> None |
| <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Unknown |
| <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Stroke | <input type="checkbox"/> <input type="checkbox"/> Other _____ |

NATURE OF ACCIDENT

Date of accident ____/____/____ Time of Day _____ Location of accident _____

Relative speed of you car _____ (mph) Relative speed of the other car _____ (mph)

What was the site of impact on your car? Where were you sitting at the time of impact?

- Behind Front Driver
 Driver's Side Passenger's Side Passenger Front Back

Were you wearing your seat belt?... No Yes Did your airbags deploy? No Yes

Were your brakes applied?..... No Yes Did your seat back break? No Yes

PLEASE DESCRIBE THE ACCIDENT in your own words: _____

List any parts of your body that struck the following vehicle parts during the accident:

Dashboard: _____ Door: _____

Windshield: _____ Door Window: _____

Steering Wheel: _____ Other: _____

Your Vehicle Type _____ Other Vehicle Type _____

Did you lose consciousness? No Yes, for how long? _____

ADDITIONAL INFORMATION:

What was your mental and emotional state immediately following the accident? _____

Were the police notified? No Yes Did you receive medical attention at the scene of the accident? No Yes

Where did you go immediately following the accident? _____

Have you been treated by another doctor since the accident? No Yes , If yes...

Please list the name of the doctor and address: _____

Please explain what type of treatment you received: _____

What type of X-rays were taken if any? _____

Do you have any congenital (from birth) factors that may relate to this problem? No Yes, _____

Do you have any previous illnesses which relate to this case No Yes, _____

Have you ever been involved in an accident before? No Yes, _____

Have you lost time from work as a result of this accident? No Yes, If yes...

Last day worked: ____/____/____ Type of employment: _____

PLEASE DESCRIBE HOW YOU FELT:

DURING the accident: _____

IMMEDIATELY AFTER the accident: _____

LATER THAT DAY: _____

THE NEXT DAY: _____

Please add any other information that you feel is pertinent: _____

PLEASE LIST YOUR CURRENT AREAS OF COMPLAINT:

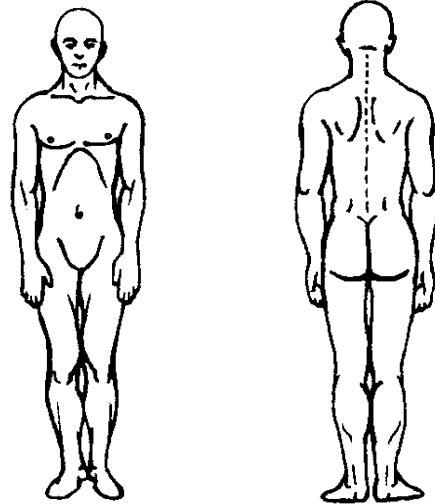
(chief complaint)

1) _____ 2) _____ 3) _____ 4) _____
0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10

CIRCLE THE NUMBER THAT BEST DESCRIBES THE INTENSITY OF YOUR PAIN: 1 = Mild, 10 = Severe

PLEASE MARK YOUR AREAS OF COMPLAINT ON THE BODY DIAGRAM USING THE FOLLOWING KEY:

- Dull = D
- Aching = A
- Stiffness = S
- Burning = B
- Tingling = T
- Numbness = N
- Sharp = !!!
- Shooting = XXX
- Other _____ = ***



How often do you notice your symptoms? Constantly Frequently Occasionally

Does anything relieve your pain? _____

What activities are difficult to perform? Sitting Standing Walking Bending Lying Down

Please describe any other activities that are restricted due to this injury? _____

Is the condition getting worse? No Yes

Have you had this problem before? No Yes, When? _____

Have you ever been diagnosed with a Subluxation? No Yes, When? _____

Have you had x-rays before? No Yes, When? _____ What areas? _____

I am currently taking the following medications for the following reasons: None

Surgical History: _____ None

For Women Only: Is there a possibility that you may be pregnant? No Yes

Which best describes your health goals: Pain relief only Correct entire problem Wellness/ preventative care

DATE: ___/___/___

SIGNATURE: _____

PARENT/GUARDIAN: _____