Name: _____ #_____ Date: _____

PLEASE FILL OUT THE FOLLOWING INFORMATION:

I have had **TRAUMA OR INJURY**: ☐ yes ☐ no describe the trauma: ☐ motor vehicle collision
other: _____
Date of injury or onset of your symptoms: _____

What are **ALL** your symptoms? **Please CIRCLE or UNDERLINE pain, soreness, or stiffness (left, right, or both):**
☐ neck pain, soreness, or stiffness
☐ upper back pain, soreness, or stiffness ☐ shoulder area pain, soreness, or stiffness (left right both)
☐ lower back pain, soreness, or stiffness ☐ knee area pain, soreness, or stiffness (left right both)
☐ pain that radiates into arms (left right both) ☐ pain that radiates into legs (left right both)
☐ numbness or tingling in arms (left right both) ☐ numbness or tingling in legs (left right both)
☐ hip / pelvic pain, soreness, or stiffness (left right both) ☐ headaches/migraines
☐ face pain or jaw pain ☐ lightheadedness or sensation of movement ☐ dizziness
☐ nausea ☐ blurred vision ☐ ears ring (left right both) ☐ memory problems
☐ other symptoms, list each symptom: _____

Have you seen any other doctors for these/this condition (if yes, list)? _____
_____

Have you tried any home or self treatment (***circle*** all that apply)? _____
ice heat stretching rest over the counter pain relievers

Have you ever previously had similar symptoms (when and describe)? _____
_____

Have you had prior chiropractic care (if yes, when)? _____

What is the severity of your pain **AND** other symptoms when they are at their worst?
☐ mild ☐ mild to moderate ☐ moderate ☐ moderate to severe ☐ severe ☐ very severe

Have you been able to work since this injury? ☐ Yes ☐ No ☐ Unemployed _____

Are your symptoms: ☐ constant ☐ intermittent (come and go)
Are your symptoms: ☐ improving ☐ worsening ☐ not changing

Are your symptoms aggravated when you cough or sneeze? _____
What makes your symptoms worse? _____
What makes your symptoms better? _____

Have you had any problems with (***circle*** all that apply)? bowels bladder heart breathing eyes N/A

List all medication that you take ***for any reason*** and ***circle*** all that you are taking due to your accident or present complaints:

_____
_____ **PATIENT INITIALS [ ]**

Back Pain Chiropractic
2006 N State Line Ave
Texarkana, AR 71854

IMPORTANT ACCIDENT INFORMATION
PLEASE COMPLETE THIS FORM TO THE BEST OF YOUR ABILITY

Your Name _____ Age_____ Today's Date_____
Your Height _____inches Weight _____lbs. Right or Left handed

ACCIDENT HISTORY: **(PLEASE CHECK, CIRCLE, OR FILL IN ANSWERS FOR ALL OF THE QUESTIONS)**

Date of accident: _____ **Was the accident on the job?** ☐ Yes ☐ No

You were: ☐ Driver ☐ Front seat passenger ☐ Middle front seat passenger ☐ Rear seat: Left / Right

Other _____ **How many people were in the vehicle you were in?** _____

Vehicle was driven by: _____

Describe the vehicle that you were in (year, make, model): _____

Your estimated speed at moment of accident: ☐ Stopped ☐ Slowing ☐ Accelerating - mph _____

Describe the other vehicle (year, make, model): _____

Time of day: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark

Road conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice other _____

Was the accident in AR or TX other? _____ **In what county?** _____

Where did the accident occur? _____

Where was the impact? Rear (driver or passenger side) Front (driver or passenger side) If side impact (driver or passenger side)

Head restraints: The top of headrest was – ☐ Above Head ☐ Below Head ☐ Level with Head

If adjustable, was the position of the head restraint altered by the accident? ☐ Yes ☐ No

Was the seat back position altered by the accident? ☐Yes ☐ No Was seat broken by the accident? ☐ Yes ☐ No

Seat belt: ☐ None ☐ Wearing ☐ Not wearing

Did **air bag** deploy? ☐ Yes ☐ No If yes, were you struck by the bag? ☐Yes ☐ No

Just prior to the impact, your hands were: ☐ One on wheel ☐ Two on wheel N/A

Were you aware of the impending crash, in time to react? (brace yourself) ☐ Yes ☐ No

DURING THE CRASH:

Your body position: ☐ Forward ☐ Turned Left ☐Turned Right Other _____

Your head position: ☐ Forward ☐ Turned Left ☐ Turned Right ☐ Up ☐ Down

Did **you** strike any part of the vehicles interior? ☐ Yes ☐ No ☐ Unsure

If yes, describe_____

Wearing hat or glasses? ☐Yes ☐ No If yes, were they still on after crash? ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No If yes, how long _____

Was your vehicle pushed by the impact? ☐ Yes ☐ No If yes, estimate how far? _____ft

Was your vehicle pushed into another vehicle? ☐ Yes ☐ No

AFTER THE ACCIDENT

Estimated property damage of the vehicle you were in: ☐ None ☐ Minimal ☐ Moderate ☐ Major ☐ Totaled $_____

Estimated damage to the other vehicle(s): ☐ None ☐ Minimal ☐ Moderate ☐ Major

Were the police on the scene? ☐ Yes ☐ No If yes, was a report made? ☐ Yes ☐ No

After the accident, when did the symptoms first appear? ☐ Immediately ☐ Hours (___) ☐ Days (___)

Describe symptoms and when they appeared (hours or days): ☐ Headaches ☐ Dizziness ☐Nausea ☐ Disorientation

☐ Neck pain ☐ Back pain ☐ Shoulder pain ☐ Left / Right arm or Left / Right leg: pain / numbness / tingling

Other symptoms: _____

Where did you go after accident? ☐ St. Michael's ER ☐ Wadley ER ☐ other Hospital: _____ ☐ Home ☐Work

How did you get there? ☐ ambulance ☐ other _____

Confidential Patient Information

The following information is needed for our files so we can better serve you as a patient. **PLEASE PRINT**

Patient's full name: _____

Address: _____

Mailing Address: _____

City, State & Zip: _____

Birth date: _____ Social Security number: _____-_____-_____

Home phone: (_____)_____ Sex: ☐ Male ☐ Female

Cell phone: (_____)_____ Texting : ☐YES ☐NO

Marital status: single married widowed divorced other: _____

Date of last menstrual period: _____

Nearest relative: _____ Phone number: _____

Reason for visit:

Related to employment: Yes No Date: _____

Related to Automobile: Yes No Date: _____

Related to other: Yes No Date: _____

History Information

Have you had any past illness? Yes No

Please list: _____

Family Physicians name: _____

Physicians phone number: _____

Any surgeries? Yes No

Please list: _____

Any accidents? Yes No

If yes when? _____

Any MRI / CT / X-rays in the past year? Yes No

Please list: _____

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Responsible Insurance
(Responsible Parties Auto Insurance)

Name of Insured _____
Name of Insurance Company_____
Address of Insurance Company: _____
City, State, Zip_____ Phone Number _____
Claim/Policy number _____/_____
Adjuster _____

Employer Information

Employer _____
Occupation _____
Address _____ City, State, Zip_____
Phone number (_____) _____

I give full permission to Back Pain Chiropractic Clinic to use any information to release to my family doctor and any other treating doctors regarding my conditions.

Patient Signature_____ Date _____

Consent to treat a minor child
(Guardian information is needed if patient is a minor)

I hereby authorize Back Pain Chiropractic Clinic to administer treatment as they deem necessary to my child.

Guardian Name _____
Date of Birth _____ Social Security number _____
Address if different from patient_____
City, State, Zip _____ Phone number _____
Signature of Guardian_____ Date _____

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PRESENT COMPLAINTS *(If any of the following are relevant to your current SYMPTOMS PLEASE ✓THE ACCOMPANYING BOX)*

- ☐ HEADACHE
- ☐ HEAD SEEMS TOO HEAVY
- ☐ HEAD & SHOULDER TIRED & HEAVY
- ☐ MENTAL DULLNESS
- ☐ LOSS OF MEMORY
- ☐ EQUILIBRIUM PROBLEMS
- ☐ DIZZINESS
- ☐ FAINTING
- ☐ TREMORS
- ☐ PALPITATION
- ☐ NECK PAIN
- ☐ NECK STIFFNESS
- ☐ NECK MOTION RESTRICTED
- ☐ UPPER BACK PAIN / STIFFNESS
- ☐ MID BACK PAIN / STIFFNESS
- ☐ LOW BACK PAIN / STIFFNESS
- ☐ PINS & NEEDLES IN ARMS/ LEGS
- ☐ NUMBNESS IN FINGERS, ARMS, LEGS
- ☐ CHEST PAIN
- ☐ SHORTNESS OF BREATH
- ☐ EYE STRAIN
- ☐ PAIN BEHIND THE EYES
- ☐ EYES SENSITIVE TO LIGHT
- ☐ EYES LOSS OF FOCUS
- ☐ DOUBLE VISION
- ☐ EAR BUZZING / RINGING
- ☐ LOSS OF TASTE
- ☐ LOSS OF SMELL
- ☐ SINUS TROUBLE
- ☐ EXTREME NERVOUSNESS
- ☐ EXTENSION
- ☐ IRRITABILITY
- ☐ ANXIETY
- ☐ EXTREME FATIGUE
- ☐ INSOMNIA
- ☐ NEURITIS
- ☐ FACE FLUSHED
- ☐ FACE PALE
- ☐ EXCESS PRECIPITATION
- ☐ DIGESTIVE DISORDER
- ☐ NAUSEA VOMITING
- ☐ DIARRHEA
- ☐ CONSTIPATION
- ☐ DEPRESSION
- ☐ SWOLLEN
- ☐ FEET / HANDS COLD
- ☐ DIFFICULTY IN PROLONGED CAR RIDING

☐ DIFFICULTY IN EXCESSIVE: ☐ STANDING ☐ WALKING ☐ RIDING ☐ BENDING
☐ NECK, LOW BACK PAIN & STIFFNESS UPON RISING
☐ PAIN RADIATING INTO: ☐ RIGHT ARM ☐ RIGHT LEG ☐ BOTH ☐ LEFT LEG ☐ LEFT ARM ☐ BOTH
☐ DIFFICULTY IN EXCESSIVE LIFTING: ☐ LIGHT ☐ MODERATE ☐ HEAVY ☐ REPETITIVE
☐ PAIN RADIATING INTO: ☐ NECK ☐ BASE OF SKULL ☐ SHOULDER ☐ HIPS

MEDICAL HISTORY *(If any of the following are relevant to your medical history, please ✓ the accompanying box. **PLEASE CHECK AT LEAST ONE BOX**.)*

- ☐ **NO KNOWN MEDICAL HISTORY**
- ☐ POLIO
- ☐ TUBERCULOSIS
- ☐ HIGH BLOOD PRESSURE
- ☐ HEART TROUBLE
- ☐ DIABETES
- ☐ HEPATITIS
- ☐ GERMAN MEASLES
- ☐ VENEREAL DISEASE
- ☐ HIV
- ☐ MUSCULAR DYSTROPHY
- ☐ MULTIPLE SCLEROSIS
- ☐ CONVULSIONS
- ☐ EPILEPSY
- ☐ CONCUSSION
- ☐ DIZZINESS
- ☐ ARTHRITIS
- ☐ NEURITIS
- ☐ RHEUMATISM
- ☐ CANCER
- ☐ RHEUMATIC FEVER
- ☐ SCARLET FEVER
- ☐ NERVOUSNESS
- ☐ ASTHMA
- ☐ DIGESTIVE DISORDERS
- ☐ SINUS TROUBLE
- ☐ BACKACHES
- ☐ NUMBNESS
- ☐ ANEMIA

Signature: _____ Date: _____

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Informed Consent for Care & X-rays

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains.

With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office

Females: I also hereby declare that to my knowledge, I am not pregnant for x-ray purposes.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature:_____ Date: _____

Witness Name: _____ Signature:_____ Date: _____