LAKE WEST CHIROPRACTIC
& NATURAL HEALTH

Patient Name_____ Date_____

Fill Out If You Have Experienced a Personal Injury

Date and time of accident_____ ( ) a.m. ( ) p.m.

Briefly describe the events that occurred just before and during your accident:
_____
_____

Give the address where the accident occurred:
_____
_____
_____

Was anyone else present during your accident? ( ) Yes ( ) No
Did you report your accident to anyone? _____ If yes, who?
_____
_____

What recommendations where made just after your accident?
_____
_____

Has this type of accident happened to you before? _____
_____

Did you have any physical complaints BEFORE THE ACCIDENT? ( ) yes ( ) no If yes, please describe in detail:
_____
_____
_____
_____

Please describe how you felt:

A) During the accident:_____
_____

B) Immediately after the accident: _____
_____

C) Later that day:_____

D) The next day_____

What are your present complaints and symptoms? _____
_____
_____

After Injury

Did the accident render you unconscious? ( ) yes ( ) no
If yes, for how long? _____

Have you gone to a hospital or seen any other Doctor? ( ) yes ( ) no

When did you go? ( ) Just after the accident ( ) The next day ( ) 2 days plus

How did you get there? ( ) Ambulance ( ) private transportation

Name of hospital and/ or attending doctor: _____
_____

Was he/she a: ( ) D.C. ( ) M.D. ( ) D.O. ( ) D.D.S

Describe any treatment you received: _____
_____

Were X-Rays taken? ( ) yes ( ) no

Was medication prescribed? ( ) yes ( ) no

Have you been able to work since this injury? ( ) yes ( ) no

Are your work activities restricted as a result of this injury? ( ) yes ( ) no

Indicate (circle) the symptoms that are a result of this accident:

Dizziness	Lower back pain	Shortness of breath
Difficulty Sleeping	Blurred vision	Stomach upset
Jaw problems	Buzzing in ear	Headache(s)
Nausea	Ears ringing	Fatigue
Memory loss	Tension	Numb hands/ fingers
Irritability	Neck pain	Back stiffness
Arms/ shoulder pain	Neck stiff	Leg pain
Back pain	Chest pain	Numb feet/ toes

Other symptoms: _____

Is your condition getting worse? ( ) yes ( ) no ( ) constant ( ) comes and goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back…….	( )	( )	( )
Lying on side…….	( )	( )	( )
Lying on stomach…..	( )	( )	( )
Sitting…….	( )	( )	( )
Standing…….	( )	( )	( )
Stretching…….	( )	( )	( )
Lovemaking…….	( )	( )	( )
Walking……..	( )	( )	( )
Running……	( )	( )	( )
Sports……..	( )	( )	( )
Working……	( )	( )	( )
Lifting…….	( )	( )	( )
Bending……	( )	( )	( )
Kneeling……..	( )	( )	( )
Pulling……	( )	( )	( )
Reaching…….	( )	( )	( )

Have you retained an attorney? ( ) yes ( ) no

If yes, whom? _____

His/Her phone # _____

Recovery

How many hours are in your normal workday? _____

Please indicate (circle) your daily job duties and any activities that you are occasionally asked to perform:

Standing	Driving	Operating equipment
Sitting	Twisting	Work with arms above head
Walking	Crawling	Typing
Lifting	Bending	Stooping

Other _____

Prior to the injury were you capable of working on an equal basis with others your age?

( ) yes ( ) no ( ) n/a

Do you work with others who can help you with any heavy lifting? ( ) yes ( ) no ( ) n/a

While in recovery, is there any light duty work you could request? ( ) yes ( ) no ( ) n/a

- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information, guarantee this form was completed correctly to the best of my knowledge, and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____-____-____

( ) Adult patient ( ) Parent or Guardian