INNOVATIVE Health
Chiropractic • Laser Therapy
Functional Medicine
2114 Schofield Avenue • Weston, WI 54476

AUTOMOBILE ACCIDENT HISTORY

Please fill out this form as completely as possible. In order for us to provide the very best care, it is important that we get a complete picture of your overall health. In addition, the U.S. Government requires that we collect certain data including your social security number, race/ethnicity, smoking status, and other demographic information as requested on this form. ***If you have any questions, please call us at 715-355-4224***

Legal Name (*First, Middle, Last*):		Today's Date:
Street Address:		Home Phone: ☐ Preferred
City / State / Zip:		Work Phone: ☐ Preferred
Social Security #:	Birthdate:	Cell Phone: ☐ Preferred
Driver's license #:	Sex: ☐ Male ☐ Female	Cell Carrier: (for text reminders)
Ethnicity: ☐ Non-Hispanic ☐ Hispanic	Email:	

Race: ☐ White/Caucasian ☐ African American/Black ☐ Hispanic ☐ Asian ☐ American Indian ☐ Alaska Native
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other: _____

Primary Medical Doctor:	Medical Doctor Clinic & City:
Emergency Contact:	Emergency Contact's Phone:
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Spouse's Name:
Spouse's Phone:	Spouse's Employer:

INSURANCE COVERAGE

If Auto Insurance, complete this section. (If Medical Insurance, skip to next section).

Name of Policyholder:	Insurance Company:
Agent's Name:	Agent's Phone Number:
Claim Number:	

If Medical Insurance, complete this section

Name of Policyholder:	Policyholder Date of Birth:
Policyholder's relationship to you:	Policyholder's Employer:
Insurance Company:	Insurance Co. Phone number:
Policy Number:	Group Number:

WORK STATUS Occupation: | Employer:

What type of physical activity is required at work?

Have you missed time from work? ☐ Yes ☐ No. If no, who told you to return to work? _____

If yes, choose one: ☐ I have been unable to return to work since accident.
☐ Off work, Full Time Dates: _____
☐ Off work, Part Time Dates: _____

Is there alternate work available for you? ☐ No ☐ Yes. If yes, please describe: _____

PRESENTING ILLNESS / CHIEF COMPLAINT

What are your symptoms?

Please describe how you felt: Immediately after the accident:

Later that day:

The next day(s):

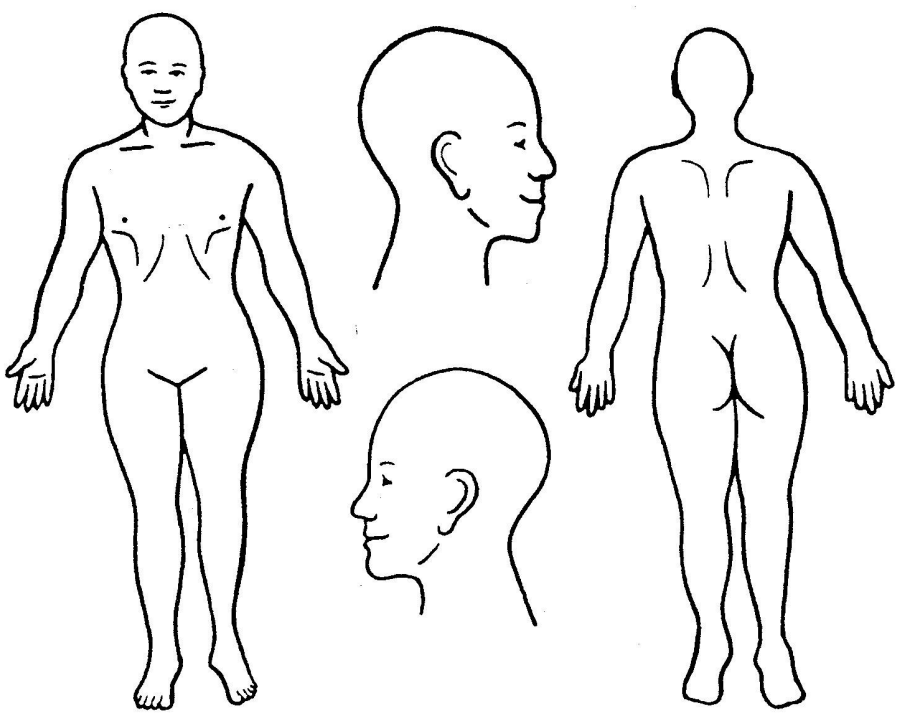
FEMALES: Are you pregnant? ☐ No ☐ Yes If Yes, Due Date: Doctor:

Show us your pain. Use the symbols from the top box on the left to indicate the location and type of pain you are having.

XXX	Burning
(((	Aching
000	Pins & Needles
- - -	Numbness
: : :	Sharp Pains

Pain is:	
____	Constant
____	Comes & Goes
____	Getting Better
____	Getting Worse
____	Staying Same

Better		Worse
____	Morning	_____
____	Midday	_____
____	Evening	_____



Rate your pain on the scale below. If there is more than one area of pain, please indicate the pain level (0 to 100) next to each area as appropriate.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

NO PAIN INTOLERABLE

What Makes the Condition Better?	What Makes the Condition Worse?
Head, Neck:	Head, Neck:
Mid Back:	Mid Back:
Low Back:	Low Back:
Shoulder, Arm, Hand:	Shoulder, Arm, Hand:
Hip, Leg, Foot:	Hip, Leg, Foot:

☐ Yes ☐ No Does the pain interfere with your sleep? # of times you wake up:_____ Sleep position: _____ # of pillows: _____

☐ Yes ☐ No Does heat affect the pain? If so, how?

☐ Yes ☐ No Does cold affect the pain? If so, how?

☐ Yes ☐ No Do you wear a heel lift? If so, which side?

Please mark any of the following activities which you find to be painful or difficult.

____ Lying on back	____ Dressing Self	____ Lifting	____ Kneeling	____ Twist/Turn Left/Right
____ Lying on side	____ Stooping	____ Gripping	____ Bending Forward	____ Sitting/Driving/Riding
____ Lying on stomach	____ Pushing/Pulling	____ Standing	____ Get In/Out of Car	____ Using Computer
____ Turning over in bed	____ Reaching	____ Walking	____ Sexual Activity	____ Going Up/Down Stairs

____ Cough / Sneeze / Grunt (If painful, where? _____)

Please mark any symptoms that have become apparent since the accident/injury.

____ Nervousness	____ Face flushed	____ Depression	____ Pins/needles, arms	____ Visual changes
____ Neck pain/stiffness	____ Ringing in ears	____ Cold hands	____ Pins/needles, legs	____ Forgetfulness
____ Mid back pain	____ Loss of balance	____ Cold feet	____ Toe numbness	____ Blurred vision
____ Low back pain	____ Loss of smell	____ Chest pain	____ Finger numbness	____ Double vision
____ Eye sensitivity	____ Loss of memory	____ Constipation	____ Headache	____ Confused
____ Pain behind eyes	____ Short of breath	____ Diarrhea	____ Fainting	____ Disoriented
____ Dizziness	____ Head feels heavy	____ Fatigue	____ Anxiety	Other: _____
____ Cold sweats	____ Irritability	____ Tension	____ Seizures	_____

PRIOR SIMILAR SYMPTOMS

☐ Yes ☐ No Did you have any physical complaints just before the accident? If yes, describe in detail:

☐ Yes ☐ No Prior to this accident, have you ever had similar symptoms? If yes, please explain:

☐ Yes ☐ No Have you had any prior symptoms, injuries, accidents, diseases, or treatment to the area of your body now affected?
If yes, which body part? When (date)?
Describe:

☐ Yes ☐ No Do you have any congenital (birth) factors that relate to this problem? If yes, please describe:

ACCIDENT INFORMATION

Date of accident:	Time of day: ☐ AM ☐ PM
Who was driving vehicle?	Where were you seated?
Vehicle owner:	Year/Model of vehicle:
Describe the damage to the vehicle you were in:	Where did the accident occur?

Were internal parts of the vehicle broken? ☐ No ☐ Yes. If yes, describe:

Your vehicle: ☐ Hit another vehicle ☐ Was hit in the: ☐ Right side ☐ Left side ☐ Rear ☐ Front

Type of accident: ☐ Head-on collision ☐ Broad-side collision ☐ Rear-end collision ☐ Front-impact (rear-ended vehicle in front of you)
☐ Single-vehicle collision ☐ Other:

Number of vehicles involved: 1 2 3 4 5 +	Year/Model of other vehicle(s):

How many people were in the vehicle?

What were road conditions at the time? ☐ Icy ☐ Rainy ☐ Wet ☐ Clear ☐ Dark

What was the visibility at the time? ☐ Poor ☐ Fair ☐ Good

In your own words, describe what happened to you upon impact:

☐ Yes ☐ No Did you see the accident coming?

☐ Yes ☐ No Did you brace for impact?

☐ Yes ☐ No Did you have your hands on the steering wheel at impact?

☐ Yes ☐ No Were you wearing glasses, a hat, or dentures? If yes, where were they after impact?

☐ Yes ☐ No Were you wearing a seatbelt?	☐ Yes ☐ No Were you wearing a shoulder harness?

☐ Yes ☐ No Does your vehicle have airbags? If yes, did they release?

ACCIDENT INFORMATION CONT'D

☐ Yes ☐ No Does your vehicle have headrests? If yes, what was the position of the headrest compared to your head after the accident?

What was your head position at the time of the accident? ☐ Facing forward ☐ Turned right ☐ Turned left

What was your body position at the time of the accident? ☐ Facing forward ☐ Turned right ☐ Turned left

☐ Yes ☐ No Was your vehicle braking?

☐ Yes ☐ No Was your vehicle moving at the time of the accident? If yes, ☐ Slowing down ☐ Speeding up ☐ Constant speed

What was the speed limit on the road you were traveling?

ACCIDENT INJURIES

☐ Yes ☐ No Did you receive any bruises from the seatbelts? If yes, where?

☐ Yes ☐ No Did you receive any other bruises? If yes, where?

☐ Yes ☐ No Did you receive any bleeding cuts? If yes, where?

☐ Yes ☐ No Did your head/body hit any parts of the interior of the vehicle? If yes, which parts?

☐ Yes ☐ No Were you able to get out of the vehicle unattended? If no, why not?

☐ Yes ☐ No Could you move all parts of your body? If no, describe:

As a result of the accident, were you: ☐ Rendered unconscious ☐ Dazed, the situation was vague ☐ Shaken up, but could function

Were you in the vehicle prior to the accident? ☐ Yes ☐ No

Were you in the vehicle after the accident? ☐ Yes ☐ No If no, describe:

FIRST DOCTOR / HOSPITAL / CLINIC

Did you seek medical attention after the accident? ☐ No ☐ Yes

If yes, how did you get there? ☐ Ambulance ☐ Police ☐ Someone else drove me ☐ Drove myself

Doctor / Hospital / Clinic:	Date of first visit: | Date of last visit:
Were you examined? ☐ No ☐ Yes	Were X-rays taken? ☐ No ☐ Yes

What diagnosis were you given?

Were you treated? ☐ No ☐ Yes If yes, describe:

What benefits did you receive from the treatment?

Did you follow the doctor's recommendations? ☐ No ☐ Yes If no, why not?

Were you referred to another provider? ☐ No ☐ Yes If yes, to whom? for what?

Did you see the referred provider? ☐ No ☐ Yes If no, why not?

SECOND DOCTOR / HOSPITAL / CLINIC

Doctor / Hospital / Clinic:	Date of first visit: | Date of last visit:
Were you examined? ☐ No ☐ Yes	Were X-rays taken? ☐ No ☐ Yes

Were you treated? ☐ No ☐ Yes If yes, describe:

What benefits did you receive from the treatment?

SOCIAL HEALTH HISTORY

Recreational Activities / Hobbies:

Do You Exercise? ☐ No ☐ Yes If Yes, in what way? How often per week?

Do you consume Caffeine (Coffee, Tea, Soda, Energy Drinks)? ☐ No ☐ Yes If Yes, how much per day?

Do you consume Alcohol (Beer, Wine, Mixed Drinks)? ☐ No ☐ Yes If Yes, how much per week?

Smoking Status *(If 13 years old or older):* ☐ Never ☐ Former (___ Packs/day or ___ Cigarettes/day from Age ____ to Age _____)
☐ Smoker—Some days (NOT daily) ☐ Smoker—Daily (____ Packs/day or ____ Cigarettes/day for _____ Years)

MEDICAL HISTORY Have you ever seen a chiropractor? ☐ No ☐ Yes If Yes, Doctor: Clinic:

List major illnesses, injuries, falls, hospitalizations, accidents, or surgeries: ☐ None

Date	Condition(s)	Treating Doctor	Results
			☐ Full Recovery ☐ Complications
			☐ Full Recovery ☐ Complications
			☐ Full Recovery ☐ Complications
			☐ Full Recovery ☐ Complications

List current prescriptions, over-the-counter medications, and supplements: ☐ None

Name	Dosage *(mg, mL, …)*	Form *(Tablets, Caps…)*	How Often *(times per day, wk, mo)*	Duration *Chronic*	*As Needed*	*Unknown*
			x's per			
			x's per			
			x's per			
			x's per			

List allergies ☐ None

Drugs, Medications (ADR):	Foods:
Environmental:	Other: (latex, animals...)

FAMILY MEDICAL HISTORY List medical conditions experienced by yourself and immediate family members in the grid below.

	Self	**Mother**	**Father**	**Sister**	**Brother**
Example:		*Breast Cancer*	*Healthy*		*Heart attack*
Eyes (glasses/contacts, cataracts, glaucoma, blindness, etc.)					
Ear, Nose, Mouth, Throat (hearing loss, ear infections, sinus issues, allergies, etc.)					
Cardiovascular (heart attack, cholesterol, high BP, congestive heart failure, pacemaker, etc.)					
Respiratory (lungs, breathing, asthma, COPD…)					
Neurological (nerve issues, weakness, numbness, etc.)					
Endocrine (thyroid, hormonal imbalances, liver…)					
Gastrointestinal (acid reflux, ulcers, IBS, gall bladder, etc.)					
Genitourinary (male/female reproductive, kidney, bladder, etc.)					
Skin (rashes, skin cancer, dryness, psoriasis, eczema, hair, etc.)					
Psychiatric (anxiety, depression, bipolar, ADD, ADHD, etc.)					
Other (please describe)					

Are you receiving treatment for any condition other than that for which you are now consulting us? ☐ No ☐ Yes. If yes, please describe:

Is there anything else you think we should know?

I certify that the above statements are true and complete to the best of my knowledge. I authorize the doctor to examine and treat my condition through the use of chiropractic care, and I give authority for these procedures to be performed.

Patient Signature: _____ Date: _____

Parent/Guardian/Legal Representative:_____ Date: _____

Staff Initials:

INFORMED CONSENT

While chiropractic care is remarkably safe, like any health care treatment, it does have some risks. It is your right as a patient to be informed of the potential risks of care so that you are fully informed in consenting to treatment.

The nature of the chiropractic adjustment - The primary treatment used by Doctors of Chiropractic is called spinal manipulative therapy. Your doctor may use his/her hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment - As a part of the analysis, examination, and treatment, a variety of tests and therapies may be used in your care including: spinal manipulative therapy, range of motion testing, muscle strength testing, ultrasound, radiographic studies (x-rays), palpation, orthopedic testing, postural analysis, basic neurological testing, hot/cold therapy, vital signs, EMS, ultrasound, spinal decompression therapy, and/or high intensity laser therapy.

The material risks inherent in chiropractic adjustment - As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. Your doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform the doctor.

The probability of those risks occurring - Fractures are rare occurrences and generally result from some underlying weakness of the bone which your doctor will check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. *Statistically speaking, the risk of stroke from unknown causes in the general population actually exceeds the risk of stroke following a chiropractic adjustment*. The other complications are also generally described as rare.

Results - As with any health care option, we cannot guarantee any particular results from our chiropractic treatment. If during the course of care, we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another qualified health care provider.

The availability and nature of other treatment options - Other treatment options for your condition may include: self-administered, over-the-counter analgesics and rest; medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers; hospitalization; surgery. There are risks and benefits with each of these options, and you may wish to discuss these risks and benefits with your primary medical physician.

The risks and dangers attendant to remaining untreated - Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed.

❖ **PREGNANCY RELEASE –** This is to certify that, to the best of my knowledge, I am not pregnant. I give my permission to perform x-ray evaluation with the understanding that x-ray can be hazardous to an unborn child. _____
(Patient Initials)

Having carefully read the above, I hereby give my informed consent to have the doctors of Innovative Health administer chiropractic care.

Patient Name (printed)	Date
X	X
Patient Signature	Parent/Guardian/Legal Representative Signature