MARVIN'S MIDTOWN CHIROPRACTIC CLINIC

I understand that if I provide inaccurate or untruthful information to the doctors or staff it could affect the course of my treatment and the accuracy of any diagnosis. If I intend to seek payment or reimbursement from an insurance company or third party payer, any such payment can only be based on a new injury or an aggravation of a pre-existing condition. I have been requested to read and acknowledge what I am writing by providing my signature below.

PATIENT NAME: _____ **DATE OF BIRTH :**_____

FAMILY AND PERSONAL TRAITS:

CONDITION	SELF	MOTHER	FATHER	CONDITION	SELF	MOTHER	FATHER
Abnormal bleeding	_____	_____	_____	Migraines	_____	_____	_____
Heart disease	_____	_____	_____	Cancer	_____	_____	_____
Kidney disease	_____	_____	_____	Diabetes	_____	_____	_____
Liver disease	_____	_____	_____	Stroke	_____	_____	_____
Lung disease	_____	_____	_____	Seizures	_____	_____	_____
High blood pressure	_____	_____	_____	Aids/HIV	_____	_____	_____
High cholesterol	_____	_____	_____	Stomach	_____	_____	_____

CURRENT COMPLAINTS: (circle)

Headaches	Arm pain/stiffness	Upper back pain/stiffness
Dizziness	Leg pain/stiffness	Mid back pain/stiffness
Blurry vision	Neck pain/stiffness	Low back pain/stiffness
Ringing ears	Shoulder pain/stiffness	Ankle pain/stiffness
Wrist pain/stiffness	Knee pain/stiffness	Elbow pain/stiffness

WHAT HAS OCCURRED:

Have you ever had surgery? _____ If yes, what kind and when? _____

I am here for treatment of an accident injury? _____ If yes, then when was accident? _____

Have you been to any other doctor or hospital for these injuries? _____ If yes, then what is the name of the doctor or hospital? _____

_____

Have you lost any time from work due to these injuries? _____ If yes, the has a doctor given you a note taking you off work? _____ If yes, then what dates? _____

Previous accidents? _____ If yes, what kind and when?_____

X_____ **DATE**: _____

MARVIN'S MIDTOWN CHIROPRACTIC CLINIC
AUTO ACCIDENT QUESTIONNAIRE

PERSONAL INFO

NAME: _____PHONE#: _____

ADDRESS: _____Apt._____ CITY: _____STATE: _____ZIP: _____

DATE OF BIRTH: ___/___/____ AGE: _____ SOCIAL SECURITY #:_____

EMPLOYER: _____EMPLOYER PHONE#: _____

EMERGENCY CONTACT: _____THEIR PHONE#: _____

HOW WERE YOU REFERRED IN: _____

ACCIDENT INFO

DATE OF ACCIDENT: _____TIME OF ACCIDENT: _____AM OR PM

WHERE DID ACCIDENT HAPPEN: _____CITY _____STATE _____

HOW DID ACCIDENT HAPPEN: _____

_____

WHO WAS DRIVING CAR YOU WERE IN? _____ HOW MUCH DAMAGE: _____

WHO OWNED CAR? _____YEAR/MAKE/MODEL: _____

NAME OF PEOPLE IN CAR AT TIME OF ACCIDENT: _____

AUTO INSURANCE CO. ON CAR YOU WERE IN: _____ THAT POLICY # _____

NAME OF PERSON WHO CAUSED ACCIDENT: _____

AUTO INSURANCE CO OF THAT PERSON: _____ THAT POLICY#_____

THAT CLAIM#: _____ THAT PHONE# _____

TYPE OF CAR THAT HIT CAR YOU WERE IN: _____

WHAT PART OF CAR DAMAGED? (FRONT, REAR, PASSENGER SIDE, DRIVER SIDE) WAS CAR (MOVING or STOPPED)

WHERE WERE YOU SEATED? (DRIVER SEAT, FRONT PASSENGER, LEFT REAR, RIGHT REAR, MIDDLE REAR)

WHICH DIRECTION WAS CAR YOU WERE IN TRAVELING? (NORTH, SOUTH, EAST, WEST) POLICE REPORT MADE? (YES or NO)

ANYONE GET TICKET? (YES or NO) DID AIRBAGS DEPLOY? (YES or NO) DID YOU SEE ACCIDENT COMING? (YES or NO)

DID YOU HAVE ON SEATBELT? (YES or NO) DID YOU HIT ANY PART OF YOUR BODY ON CAR? (YES or NO)

WERE YOU KNOCKED UNCONSCIOUS? (YES or NO) UPON IMPACT WAS YOU BODY THROWN? (FORWARD, BACKWARD, LEFT, RIGHT)

DID YOU GO TO HOSPITAL IN AMBULANCE? (YES or NO) IF SO WHICH HOSPITAL? _____

x_____ **DATE** _____

SIGNATURE OF PATIENT OR GUARDIAN ADULT