Proactive Chiropractic Group
12426 S Van Dyke Road, Suite 100
Plainfield, IL 60585
815-782-6903

New Patient Registration and Accident Questionnaire

Name: ____ Age: _________Date of birth: _____________ Date: ___________
LAST FIRST MIDDLE

Address: ______________________________________Social Security #: _______________________ ・ Male ・ Female

City, State, Zip: _________________________________Marital Status: ・ M ・ S ・ W ・ D # of Children__________

Home Phone (_____)_____________________________Work Phone (_______) _________________________________

Cell Phone (_____) ______________________________Email address: ____

Employer: ____________________________________ Spouse's Name: ____

Occupation: __________________________________ Spouse's Employer: ______________________________________

In case of emergency, notify______________________ Relationship: ____________ Phone (_______) ___________

Current Symptoms: 1.__________________ 2.__________________ 3.__________________ 4.______________________

5. __________________ 6. __________________ 7. __________________ 8. __________________

When did your symptoms begin? ____

In general what makes your symptoms better? ____

In general what makes your symptoms worse? ____

In general how would you describe your pain? (ache, burn, dull, sharp, throbbing): ________________________________

Are your symptoms local or do they travel to another area? (If they travel, to where?) ______________________________

Are symptoms; ・Constant >76% ・Frequent 51-75% ・Occasional 26-50% ・Intermittent <25% **of your waking hours**

Were there any symptoms you had after the accident that have now resolved? (please list)

____

Please list all medications and dosage: Frequency For What Illness?

____

____

List any allergies to medications, foods or other: ____

Are you pregnant? ・ Yes ・ No First day of last menstrual cycle: ____

Do you smoke? ・ Yes ・ No; How much? ___________ Do you drink alcohol? ・ Yes ・ No; How much? ___________

Please list all serious illnesses and serious accidents: Month and Year City, State

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____

____

Please list any recent x-rays, lab or other tests: Date Facility/Doctor

____

____

Date of Accident: ________________________________ Hour: ____________AM __________PM _______________

Specific Location of Accident: ____

Describe in detail, in your own words, how the accident happened: _______________________________________

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____

AUTOMOBILE/MOTORCYLCE ONLY

In the accident: Were you the · Driver · Passenger · Pedestrian · Other? ______________________________

Did your vehicle strike the other vehicle? · Yes · No Did the other vehicle strike your car? · Yes · No

Were you struck from? · Behind · Front · Driver Side · Passenger Side **Motorcycle Only**: · Left Side · Right Side

Were traffic citations issued to? · You · Driver of Your Vehicle · Driver of the Other Vehicle · No Citations Given

Was your vehicle heading? · North · South · East · West on _____________________________ (Street/Highway)

Was the other heading? · North · South · East · West on _______________________________ (Street/Highway)

CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

- Headache
- Middle Back Pain
- Lower Back Pain
- Ears Ring
- Neck Pain
- Chest Pain
- Lower Back Stiffness
- Buzzing in Ears
- Neck Stiffness
- Bruised Chest
- Radiating Pain
- Dizziness
- Sleeping Problems
- Bruising Anywhere
- Tingling in Legs
- Loss of Smell
- Depression
- Blurred Vision
- Tingling in Arms
- Loss of Taste
- Anxiety
- Sensitivity to Light
- Jaw Pain
- Any Burns
- Fainting
- Upper Arm Pain
- Upper Leg Pain
- Any Stitches
- Muscle Spasms
- Lower Arm Pain
- Lower Leg Pain
- Any Cuts
- Other Symptoms: ____

Have you lost time from work? · Yes · No: If Yes, Dates: ____________________ to ______________________

Where did you go after the accident? · Hospital · Urgent Care · Home · Work · Other ____________________

Were you taken by ambulance? · Yes · No **To which hospital?** _______________________________________

Address: ____ Date of Hospitalization: ____________________

Attending E.R. Doctor: _________________________________ Treatment Given? ____________________________

Have you done any of the following since the accident:

- Ice
- Rest
- Medication (name)_______
- Heat (any kind)
- Exercise
- Other________________________

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:

Tuberculosis	· Yes	Lung Disease	· Yes	Gout	· Yes	Diabetes	· Yes
Kidney Disease	· Yes	Stomach/Ulcer	· Yes	Heart Disease	· Yes	Hepatitis	· Yes
Sciatica	· Yes	Blood Pressure	· Yes	Transfusion	· Yes	Polio / MS	· Yes
Colon Disease	· Yes	Stroke	· Yes	Cancer	· Yes	Bleeding	· Yes
Paralysis	· Yes	Seizures	· Yes	Arthritis	· Yes	Asthma	· Yes
Anemia	· Yes	Thyroid Disease	· Yes	AIDS	· Yes	Drug Dependence	· Yes

HIPAA Compliance

Our office is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature: ________________________________ Date: ___________________________________

Witness: ____Date: ___________________________________