PURE LIFE CLINIC

Name:_____ Date of Birth: _____

Motor Vehicle Accident Registration

Patient Information

Today's Date: _____

Patient Name: _____

Address: _____

_____

_____

Email_____

Patient SS#_____

Sex/Gender: _____

Preferred Pronoun (please circle):

He/Him She/Her They/Their Other: _____

Age_____ **Birthdate**_____

Marital Status_____

Spouse's Name_____

CONTACT

Home_____

Cell_____

Other_____

May we leave a message? Yes No

Occupation_____

Employer_____

Employer Phone_____

IN CASE OF EMERGENCY, CONTACT:

Name_____

Relationship_____

Phone_____

Accident Information

Is condition due to accident: YES NO

Date of accident_____ State_____

Type of accident: AUTO WORK HOME

To whom have you made a report of your accident?

_____

_____

Insurance

Auto Insurance Company_____
Claim #_____
Adjuster Name_____
Phone_____Ext_____
Claim Coverage Amount _____
Health Insurance_____
ID #_____
Third Party Auto Insurance_____
Name of the insured_____
Claim #_____
Adjuster Name_____
Phone_____Ext_____
Claim Coverage Amount _____

How Did you find us?

- □ Google
- □ Yelp
- □ Friend
  Their name: _____
- □ Chair massage event
- □ Insurance provider

Other:_____

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Patient History and Condition

Describe the conditions/symptoms you are currently experiencing:

Concern #1:_____

Concern #2:_____

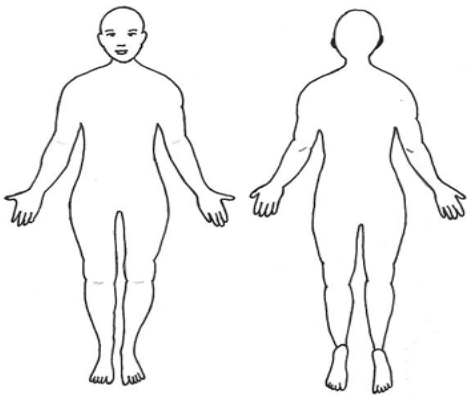
Concern #3:_____

	Condition #1	Condition #2	Condition #3
When did these symptoms begin?	_____	_____	_____
Is the condition getting progressively worse?	_____	_____	_____
Rate the severity of your pain from 1 to 10	_____	_____	_____
How often do you experience these symptoms?	_____	_____	_____
Is the pain constant or varied in duration?	_____	_____	_____
Describe the pain using words below	_____	_____	_____
(Sharp/Dull, Throbbing, Aching, Shooting,	_____	_____	_____
Burning, Cramps, Stiffness, Swelling)	_____	_____	_____
Does the pain interfere with your….			
[Circle any that apply for each condition]	Work/Recreation/ Daily Routine/Sleep	Work/Recreation/ Daily Routine/Sleep	Work/Recreation/ Daily Routine/Sleep
Does it cause numbness, tingling, or weakness?	_____	_____	_____
What treatment/therapy have you tried?	_____	_____	_____
Have you experienced this condition previously?	_____	_____	_____
If yes, when did you previously experience it?	_____	_____	_____
Has the issue resolved previously?	_____	_____	_____

Any additional concerns? _____

Have you ever seen a: Chiropractor? _____ Acupuncturist? _____ Licensed Massage Therapist? _____

Mark an **X** on the picture where you continue to experience symptoms.



List activities that are painful, such as sitting, standing, etc:

_____

_____

_____

Have you received care for your current condition? _____

Do you have children: _____ if yes, list ages: _____

Clinician Signature:_____ **Date**_____

PURE LIFE CLINIC

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Health History

Have you recently experienced any of the following (*circle all that apply*):

Bowel/Bladder changes Significant weight loss/gain Sweats/Chills/Cough Significant fatigue

Date of Last:

Physical Exam:_____ Spinal X-ray: _____ Blood Test: _____ Urine Test: _____

Spinal Exam: _____ Chest X-ray: _____ Dental X-ray: _____

MRI/CT Scan/Bone Scan: _____ Blood Pressure: _____/Reading: _____

List the following	Description	Date
Falls/Major trauma		
Head injuries		
Broken bones/Dislocations		
Surgeries/Hospitalizations		

Please circle to indicate if you have had any of the following:

AIDS/HIV	Cancer	Hernia	Pacemaker	Thyroid Problems
Alcoholism	Cataracts	Herniated Disk	Parkinson's disease	Tonsillitis
Allergy Shots	Chemical Dependency	Herpes	Pinched Nerve	Tumors, growths
Anemia	Chicken Pox	High Cholesterol	Pneumonia	Typhoid Fever
Anorexia	Dizziness	Kidney Disease	Polio	Ulcers
Appendicitis	Emphysema	Liver Disease	Prostate problem	Vaginal Infections
Arthritis	Epilepsy	Low Blood Pressure	Prosthesis	Venereal Disease
Asthma	Fractures	Measles/ Mumps	Psychiatric care	Whooping Cough
Bleeding Disorders	Glaucoma	Migraine Headaches	Rheumatoid arthritis	Other:_____
Breast Lump	Goiter	Mononucleosis	Scarlet fever	_____
Bronchitis	Gout	Multiple Sclerosis	Stroke	None of the Above
Bulimia	Headaches	Osteoporosis	Suicide attempt	

Please indicate any significant illnesses you or a blood relative (Grandparent, parent, sibling) have had:

Illness	Me (M) or Relative (R)	Approximate Date	Illness	Me (M) or Relative (R)	Approximate Date
Cancer	M R		Diabetes	M R	
Hepatitis	M R		Heart Disease	M R	
High Blood Pressure	M R		Seizures	M R	
Rheumatic fever	M R		Emotional Disorders	M R	
Infectious Disease	M R		Tuberculosis	M R	
STD	M R		Other illness	M R	

Medications	Allergies	Vitamins/Herbs/Minerals

Clinician Signature:_____ **Date**_____

PURE LIFE CLINIC

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Health History (Continued)

OB/GYN History:

Are you, or do you have any reason to believe you may be, pregnant? **Yes** **No** **Unsure**

If yes, how far along are you? _____ Due Date? _____

Menstrual/Birthing History:

Age of first menses: _____ # of days of menses: _____ Length of cycle: _____
# of pregnancies: _____ # of miscarriages: _____ # of abortions: _____
# of live births: _____ __ Birth control type: _____

Have you been diagnosed with:

☐ Fibroids ☐ Endometriosis ☐ Fibrocystic Breasts ☐ Ovarian Cysts ☐ PID ☐ Other ____

Female Reproductive/Breasts (please check any that you experience now and underline any that you have experienced in the past):

[ ] Menopausal Symptoms [ ] Nipple Discharge [ ] Sexual Difficulties
[ ] Vaginal Discharge [ ] Difficulty Conceiving [ ] Heavy Flow or clotting
[ ] Irregular Cycles [ ] Painful Periods [ ] Premenstrual Problems
[ ] Bleeding Between Cycles [ ] Libido Issues [ ] Breast Lumps/Tenderness

Male Reproductive (please check any that you experience now and underline any that you have experienced in the past):

[ ] Sexual Difficulties [ ] Prostrate Problems [ ] Frequent Urination/ Nocturia
[ ] Testicular Pain/Swelling [ ] Penile Discharge [ ] Delayed Stream/Retention of Urine
[ ] Impotence [ ] Premature Ejaculation [ ] Post void dribbling

LIFESTYLE

Occupation: _____ Hours worked per week: _____

Daily routine:

a. Do you typically eat at least three meals per day? Yes No If no, how many?_____
b. Exercise routine: _____
_____
c. How many hours per night do you sleep? _____ Do you wake rested? Y N
d. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____
e. Interests and hobbies:_____

Lifestyle Habits (please circle all that apply)

Exercise	**Work Activity**
None	Sitting
Moderate	Standing
Daily	Light labor
Heavy	Heavy labor

Habits	
Smoking	Packs/day:
Alcohol	Drinks/week:
Coffee/Caffeine	Cups/day:
High Stress Level Y N	Reason:

Clinician Signature:_____ **Date**_____

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Do you follow a specific diet (please explain):

_____

_____

Symptom Survey

Please indicate as follows: (-) = sometimes experience OR (+) = frequently experience

__ Lack of appetite
__ Excessive appetite
__ Loose stool/Diarrhea
__Digestive problems
__Vomiting
__ Belching/burping
__ Heartburn/reflux
__ Bloating
__ Obsessive about work/relationships/etc.
__ Insomnia/Difficulty sleeping
__ Heart palpitations
__ Cold hands and feet
__ Nightmares
__ Mentally restless

__ Abdominal Pain
__ Laughing for no reason
__ Angina pains
__ Chest pain
__ Sciatic pain
__ Headaches
__ Pain or coldness in the genital area
__ Cough
__ Shortness of breath
__ Decreased sense of smell
__ Nasal problems
__ Skin problems
__ Claustrophobia

__ Bronchitis
__ Colitis or diverticulitis
__ Constipation
__ Hemorrhoids
__ Recent use of antibiotics
__ Eye problems
__ Jaundice (yellowish eyes/skin)
__ Difficulty digesting oily foods
__ Gall stones
__ Light colored stool
__ Soft or brittle nails
__ Easily angered/agitated

__Difficulty in making plans or decisions
__ Muscle spasms/twitching
__ Low back pain
__ Knee problems
__ Hearing impairment
__ Ear ringing
__ Kidney stones
__ Decreased sex drive
__ Hair loss
__ Urinary problems
__ Fatigue
__ Edema

__ Blood in stool
__ Black tarry stool
__ Easily bruised
__ Difficult to stop bleeding
__ Asthma
__ Tendency to catch cold easily
__ Intolerant to weather changes
__ Hay fever
__ Dizziness
__ Tendency to faint easily
__ Other:_____
_____

****Other information you would like to report/ may be relevant to your medical history?****

_____

_____

----------Doctor's Notes----------

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Clinician Signature:_____ **Date**_____

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PURE LIFE CLINIC

Name:_____ Date of Birth: _____

AUTO ACCIDENT QUESTIONNAIRE

Patient's Name _____ **Today's Date** _____

1. Date of Accident _____ Time of Accident _____ ☐ AM ☐ PM
2. Name of Driver of Car _____ Where were you seated? _____
3. Type of Accident: ☐ head-on collision ☐ broad-side collision
   ☐ rear-end collision ☐ front impact, rear-ended car in front
   ☐ non-collision (describe: _____)
4. Describe, in your own words, what happened to you upon impact: _____

   _____
5. Did you brace for impact? ☐ Yes ☐ No
6. Were shoulder harnesses worn? ☐ Yes ☐ No
7. Were you surprised by the impact? ☐ Yes ☐ No
8. Were seat belts worn? ☐ Yes ☐ No
9. Was the car braking? ☐ Yes ☐ No
10. Does the car have headrests? ☐ Yes ☐ No

   If yes, what was the position of the headrest compared to your head before the accident?
   The top of the headrest was even with: ☐ TOP of head ☐ BOTTOM of head ☐ middle of NECK

11. Head/body position at the time of impact: ☐ head turned __left / __right ☐ head looking back
    ☐ body straight in sitting position ☐ body rotated __left / __right ☐ head straight forward
    ☐ other (describe: _____)
12. At the time of the accident, recall what parts of your head or body hit what parts on the inside of the car: _____

    _____

    _____
13. As a result of the accident, you were: ☐ rendered unconscious ☐ dazed, circumstances vague
    ☐ other (describe: _____)
14. Could you move all parts of your body? ☐ Yes ☐ No *If no*, what parts and why? _____

    _____

    _____
15. Were you able to get out of the car and walk unaided? ☐ Yes ☐ No *If no*, why not? _____

    _____
16. What bleeding cuts did you get from this accident? _____
17. What bruises did you get from this accident? _____

Clinician Signature:_____ **Date**_____

PURE LIFE CLINIC

Name:_____ Date of Birth: _____

18. Describe how you felt immediately after the accident. Please be specific. _____

_____

19. Describe how you felt later that ☐ day ☐ night _____

_____

20. Describe how you felt the next ☐ day ☐ days _____

_____

21. Check symptoms that have been apparent <u>since</u> the accident:

☐ headache	☐ loss of smell	☐ numbness in toes	☐ cold hands
☐ neck pain / stiffness	☐ loss of taste	☐ numbness in fingers	☐ cold feet
☐ mid-back pain	☐ loss of memory	☐ loss of balance	☐ diarrhea
☐ low back pain	☐ fatigue	☐ shortness of breath	☐ chest pain
☐ sensitivity to light	☐ tension	☐ dizziness	☐ fainting
☐ constipation	☐ pain behind eyes	☐ nervousness	☐ irritability
☐ depression	☐ cold sweats	☐ ringing/buzzing ears	☐ anxiety

☐ sleeping problems ☐ other _____

22. Occupation _____ Employer_____

23. Have you missed time for work? ☐ Yes ☐ No If yes, please indicate date range:

full-time off work _____ to _____

part-time off work _____ to _____

24. Did you seek medical help immediately / soon after the accident? ☐ Yes ☐ No

If yes, how did you get there? ☐ someone drove me ☐ drove my own car ☐ ambulance ☐ police

☐ other _____

25. Doctor / Hospital / Clinic seen: _____

_____ Date _____

26. Were you examined? ☐ Yes ☐ No

27. Were x-rays taken? ☐ Yes ☐ No If yes, what body part(s) _____

28. What treatment was given to you? ☐ bed rest ☐ brace ☐ physiotherapy ☐ drugs

☐ adjustments ☐ other _____

29. What benefits did you receive from the treatment(s)? _____

_____

30. Date of last treatment: _____

31. Have you sought or had any treatment other than the doctor listed above? ☐ Yes ☐ No

Doctor / Hospital / Clinic seen: _____

Clinician Signature:_____ **Date**_____