

**NARDONE CHIROPRACTIC**

1076 EAST BETHLEHEM BLVD.

WHEELING, WV 26003

**\*CONFIDENTIAL PATIENT INFORMATION\***

**Patient Information**

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone# \_\_\_\_\_ SS# \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Sex:  Male  Female Marital Status:  Single  Married  Divorced Student:  Full  Part

Spouse / Significant Other : \_\_\_\_\_ Phone : \_\_\_\_\_

Name/Phone of Nearest Friend/Relative Not Living With You: \_\_\_\_\_

Have you ever had chiropractic care?  Yes  No

Your Health Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

**Present Complaint** (Circle the number on the pain scale for each symptom that best describes your pain)

Please describe your symptoms briefly: \_\_\_\_\_ (No Pain) **Pain Scale** (Severe)

1. \_\_\_\_\_ ( --1-2-3-4-5-6-7-8-9-10-- )

2. \_\_\_\_\_ ( --1-2-3-4-5-6-7-8-9-10-- )

3. \_\_\_\_\_ ( --1-2-3-4-5-6-7-8-9-10-- )

Are These Symptoms Due to an Accident?  Yes  No Type of Accident:  Auto  Work  Other

Date of Accident: \_\_\_\_\_ Accident Reported:  Yes  No  Worker's Comp  Insurance  Employer

Medical treatment for this Condition: Where : \_\_\_\_\_ When : \_\_\_\_\_

Have you Retained an Attorney for this Accident?  Yes  No

Name of Attorney : \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Person at Fault for the Accident: \_\_\_\_\_ Is there a claim open?  Yes  No

Insurance Company of the at Fault: \_\_\_\_\_ Claim # \_\_\_\_\_

Have you opened a claim with your Auto Insurance?  Yes  No

Name & Phone # of Your Auto Ins.: \_\_\_\_\_ Claim # \_\_\_\_\_

Have you ever been involved in a previous Auto or Work accident?  Yes  No When: \_\_\_\_\_

**Medical / Social / Work History:** (check box if it applies to you, parents, siblings or children)

- |   |  |   |  |  |
|---|--|---|--|--|
| <input type="checkbox"/> Anemia         | <input type="checkbox"/> Muscular Dystrophy  | <input type="checkbox"/> Rheumatic Fever    | <input type="checkbox"/> Allergies     | <input type="checkbox"/> Cancer        |
| <input type="checkbox"/> Polio          | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Scarlet Fever      | <input type="checkbox"/> HIV           | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> German Measles      | <input type="checkbox"/> Nervousness        | <input type="checkbox"/> Numbness      | <input type="checkbox"/> Convulsions   |
| <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Concussion          | <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Neuritis      | <input type="checkbox"/> Rheumatism    |
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Venereal Disease   | <input type="checkbox"/> Backaches     | <input type="checkbox"/> Tuberculosis  |
| <input type="checkbox"/> Liver Disease  | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Thyroid Disease    | <input type="checkbox"/> Alcoholism    | <input type="checkbox"/> Hepatitis     |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Digestive Disorder | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Other         |

Surgeries/Major Illnesses You Have Had \_\_\_\_\_ Dates: \_\_\_\_\_

Medications You are Currently Taking & Why \_\_\_\_\_

Do You? (circle) Drink Regularly Smoke Take Recreational Drugs Eat a Poor Diet

Exercise Regularly  Yes  No What is your Dominant Hand  Right  Left

Do You Work Around Hazardous Substances?  Yes  No Please list \_\_\_\_\_

Would you like us to send your records to your Family Physician?  Yes  No

Name & phone # of Family Physician \_\_\_\_\_

**Females Only – Are You Pregnant?**  Yes  No

**Patient Signature** \_\_\_\_\_

**\*PLEASE TURN OVER\***

**\*Please complete if you were involved in an auto accident**

**History of Injury:**

What is the claim # of your accident? \_\_\_\_\_

Adjusters name: \_\_\_\_\_

Who gave you the estimate?  Your Insurance Company  Other Drivers Insurance Company  Body shop

Were you the:  Driver  Front seat passenger  Back seat passenger  On the job at time of accident

Was anyone else in the car with you during the accident?  Yes  No Who? \_\_\_\_\_

Description of the vehicle you were in: Make \_\_\_\_\_ Model \_\_\_\_\_ Year \_\_\_\_\_

Portion of the vehicle hit:  Right Front  Left Front  Right Rear  Left Rear  Right Side  Left Side  Other \_\_\_\_\_

Description of other vehicle: Make \_\_\_\_\_ Model \_\_\_\_\_ Year \_\_\_\_\_

Was your car stopped at the time of the accident?  Yes  No If you were the driver, was your foot on the brake? \_\_\_\_\_

Was your vehicle moving at time of impact?  Yes  No If yes, was car  slowing down  speeding up  steady rate

Estimated rate of speed \_\_\_\_\_ (mph) Time of day  Daylight  Dawn  Dusk  Dark  Unknown

Road Conditions  Dry  Damp  Wet  Snow  Ice  Other \_\_\_\_\_  Unknown Head restraints:  Up  Down  Unknown

Seat Position after accident:  Was Altered  Was Not Altered  Don't Know Seat after accident:  Broken  Not Broken

Lap Seat Belt:  Worn  Not Worn  Don't Know Shoulder Seat Belt:  Worn  Not Worn  Don't Know

Airbag deployed:  Yes  No If yes, were you:  Struck  Not Struck Hands on wheel:  One  Two

Body position at time of accident:  Good  Forward  Leaning  Other \_\_\_\_\_  Unknown

Head position at time of accident:  Forward  Left  Right  Up  Down  Other \_\_\_\_\_  Unknown

Aware of crash:  Aware  Surprised Did you brace yourself?  Yes  No If yes,  Braced with arms  Braced with legs

Did this cause further injury?  Yes  No If yes, please explain \_\_\_\_\_

**During / After Crash:**

Patients body:  Jolted  Thrown about  Stunned  Dazed  Whipped  Slammed  Other \_\_\_\_\_

Did patient's body strike interior of car?  Yes  No If yes, please complete all that apply:

My  Head hit \_\_\_\_\_ My  Right  Left Shoulder hit \_\_\_\_\_

My  Right  Left Hip hit \_\_\_\_\_ My  Right  Left Knee hit \_\_\_\_\_

My  Chest hit \_\_\_\_\_ My  Right  Left Arm hit \_\_\_\_\_

My  Right  Left Leg hit \_\_\_\_\_ My  Other body part hit \_\_\_\_\_

Were you wearing glasses at the time of the accident?  Yes  No If yes, were the glasses still in place after impact?  Yes  No

Unconscious?  Yes  No If yes, unconscious for \_\_\_\_\_ (min.) Estimated damage to your car: \$ \_\_\_\_\_

Damage to other car:  Minimal  Moderate  Major  Totaled Was anyone cited?  Yes  No Who?  You  Other driver

Symptoms first appeared:  Immediately  \_\_\_\_\_ hours after the accident  The next day  \_\_\_\_\_ days

After the accident I went:  Home  Work  Hospital  Family Physician  Other \_\_\_\_\_

If you went to the hospital after the accident, please complete the following:

Name of hospital \_\_\_\_\_ City \_\_\_\_\_ Length of stay \_\_\_\_\_

How did you get to the hospital?  Ambulance  Other \_\_\_\_\_

What body parts were x-rayed and what treatment was given? \_\_\_\_\_

What did they tell you was wrong? \_\_\_\_\_

**\*\* Please complete if you were injured at work:**

What is the job classification of your normal job? \_\_\_\_\_

Do you:  Sit at desk  Walk  Stand  Stoop  Hold  Carry  Drive a company vehicle  Load  Other \_\_\_\_\_

Do you carry anything or pick anything up?  Yes  No If "yes", what? \_\_\_\_\_

How did the injury occur? \_\_\_\_\_

Who saw the accident? \_\_\_\_\_ Title \_\_\_\_\_

How long have you been at your job? \_\_\_\_\_ Has there been time lost at work from your injury? \_\_\_\_\_

If "yes", please explain (include dates): \_\_\_\_\_

Type of lighting in building:  Fluorescent  Overhead  On machine  Other \_\_\_\_\_

Do you pick up or lift?  Yes  No If "yes", how much? \_\_\_\_\_ How often? \_\_\_\_\_

From where to where? \_\_\_\_\_ Do you lift from:  Ground  Bench  Platform

Do you lift in or out of a machine?  Yes  No If working at a machine, do you  Sit  Stand  Kneel

In your job, do you push or pull?  Yes  No If yes, give specifics: \_\_\_\_\_

Is your work area:  Oily  Dirty  Slippery  Other \_\_\_\_\_

Do you use foot or hand levers?  Yes  No Do you work overhead?  Yes  No

How many employees have been injured doing your job? \_\_\_\_\_ Do you like your job?  Yes  No

Was a pre-employment exam performed or required?  Yes  No If off work, do you want to return to your job?  Yes  No

What changes would you make in your job? \_\_\_\_\_

Patient signature \_\_\_\_\_