SEATTLE CHIROPRACTIC
SPINE & INJURY CENTER

Today's Date: _____

Patient Information

Name: _____ Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Primary Phone: _____ Work Phone: _____

Best time to reach you: _____

SS#: _____ Height: _____ Weight: _____

Sex: □ Male □ Female Status: □ Single □ Married □ Widowed □ Divorced □ Separated

Occupation: _____ Employer: _____

□ Full-Time □ Part-Time □ Unemployed If unemployed, is this due to your pain condition? □ Yes □ No

Emergency Contact/Relationship: _____ Phone: _____

Physician Information

Primary Care MD: _____ Phone number: _____

Physicians currently involved in care:	Phone number:
_____	_____
_____	_____
_____	_____
_____	_____

Accident Information

Is your current condition due to an accident? □ Yes □ No

If so, what kind of accident?
- □ Worker's Compensation
- □ Auto Accident
- □ Other _____

To whom have you made a report of this accident?
- □ Auto Insurance
- □ Employer
- □ Worker's Compensation
- □ Other

Attorney Name (if applicable): _____ Phone: _____

Patient's Name: _____

What type of accident were you involved in? *(e.g. car, bike, etc.)* _____

Date of accident: _____ Time: _____ City: _____

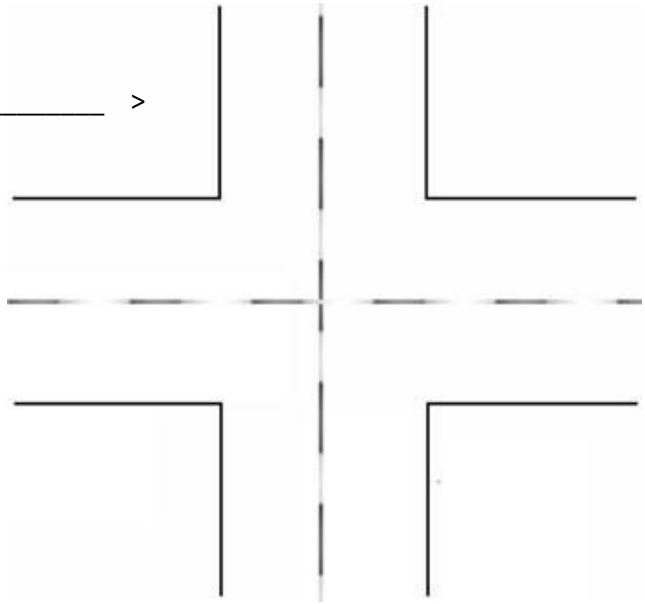
Location of accident *(area, street, etc.)*: _____

Direction of your travel *(e.g. North, South)*:_____

Direction of other vehicle's travel: _____

Please indicate on the diagram what happened:

Street name: _____ >



Street name: _____ >

Your vehicle motion at time of accident: *(check all that apply)*
□ Forward □ Stopped □ Turning left
□ Backward □ Braking □ Turning right

Other vehicle's motion: *(check all that apply)*
□ Forward □ Stopped □ Turning left
□ Backward □ Braking □ Turning right

Where were you sitting in the vehicle? □ Driver's seat □ Passenger's seat □ Other _____

Were you wearing a seatbelt? □ Yes □ No

Did airbags deploy? □ Yes □ No If yes, did you get airbag burns? □ Yes □ No

Approximate speed of your vehicle: _____mph Approximate speed of other vehicle: _____mph

Your vehicle Make: _____ Model: _____ Year: _____

Other vehicle Make: _____ Model: _____ Year: _____

Impact to vehicle: *(check all that apply)*

□ Front/Left □ Rear/Left □ Center/Right
□ Front/Center □ Rear/Center □ Back/Right
□ Front/Right □ Rear/Right □ Left/Center

Please email photos from accident to seattlechiropractic@gmail.com

Patient's Name: _____

Where were you looking at the time of the accident?

□ Not sure
□ Straight ahead
□ Down
□ To the left
□ To the right
□ Over left shoulder
□ Over right shoulder
□ Up, into the rear-view mirror
□ Down, into the left side-view mirror
□ Right, into the right side-view mirror

Were you surprised by the impact?

□ Yes □ No

Did you brace for the impact?

□ Yes □ No

Please provide as much detail as possible about how the accident occurred:

_____
_____
_____
_____
_____

Were any items thrown around in your vehicle? □ No □ Yes _____
Did your vehicle strike anything? □ No □ Yes _____
Did the other vehicle strike anything? □ No □ Yes _____

Did police arrive at the scene of the accident? □ No □ Yes
Was a police report filed? □ No □ Yes
If yes, on what date was the report filed? _____ Report #: _____
Were any traffic citations issued to you or others as a result of the accident? *(check all that apply)*

□ No
□ Yes, to me
□ Yes, to the driver of my vehicle
□ Yes, to the driver of the other vehicle

Did paramedics arrive at the scene of the accident? □ No □ Yes
Was paramedical care offered? □ No □ Yes
Was paramedical care given? □ No □ Yes

How did your vehicle leave the scene? □ It was driven □ It was towed
How did the other vehicle leave the scene? □ It was driven □ It was towed
How did you leave the scene? _____

Estimated damage to your vehicle: $_____ Estimated damage to other vehicle: $_____

Did your body make contact with the inside of the vehicle? □ No □ Yes
If yes, what part of your body made contact? *(check all that apply)*

□ Front of head
□ Back of head
□ Left side of head
□ Right side of head
□ Left shoulder
□ Right shoulder
□ Left arm
□ Right arm
□ Left knee
□ Right knee
□ Left leg
□ Right leg
□ Left foot
□ Right foot
□ Left chest/side
□ Right chest/side
□ Other _____

Patient's Name: _____

What part of the vehicle interior impacted what part of your body? *(check all that apply)*

□ Airbag hit _____ □ Headrest hit _____
□ Armrest hit _____ □ Seat hit _____
□ Dashboard hit _____ □ Steering wheel hit _____
□ Door hit _____ □ Window hit _____
□ Flying objects inside vehicle hit _____ □ Other _____

Did you lose consciousness at any time? □ No □ Yes If yes, for how long? _____

Please list any injuries/pain you noticed immediately following the accident:

_____
_____
_____

If any injuries/pain were not immediately noticeable, please list when you noticed what:

_____ Date: _____
_____ Date: _____
_____ Date: _____

What injuries/pain did you have prior to the accident?

_____ When/for how long? _____
_____ When/for how long? _____
_____ When/for how long? _____

Were there any cuts or bruising due to the accident? □ No □ Yes If yes, where? _____
Please email images to seattlechiropractic@gmail.com.

Were you hospitalized following the accident? □ No □ Yes If so, when? _____
For how long? _____ Where? _____

Have you had an MRI or X-rays taken since the accident? □ No □ Yes If so, please list below.
Area of body: _____ Date: _____ Location: _____
Area of body: _____ Date: _____ Location: _____
Area of body: _____ Date: _____ Location: _____
Area of body: _____ Date: _____ Location: _____

What treatment(s) have you received since the accident? *(check all that apply)*
□ Medical □ Naturopathic □ Chiropractic □ Sports/Exercise □ Other _____

Doctor's Name: _____Location: _____ Visit dates: _____
What did he/she say was wrong? _____

Doctor's Name: _____Location: _____ Visit dates: _____
What did he/she say was wrong? _____

Doctor's Name: _____Location: _____ Visit dates: _____

Patient's Name: _____

What did he/she say was wrong? _____

Did you take time off work as a result of this accident? □ No □ Yes If so, as of what date? _____
Have you returned to work? □ No □ Yes If so, as of what date? _____

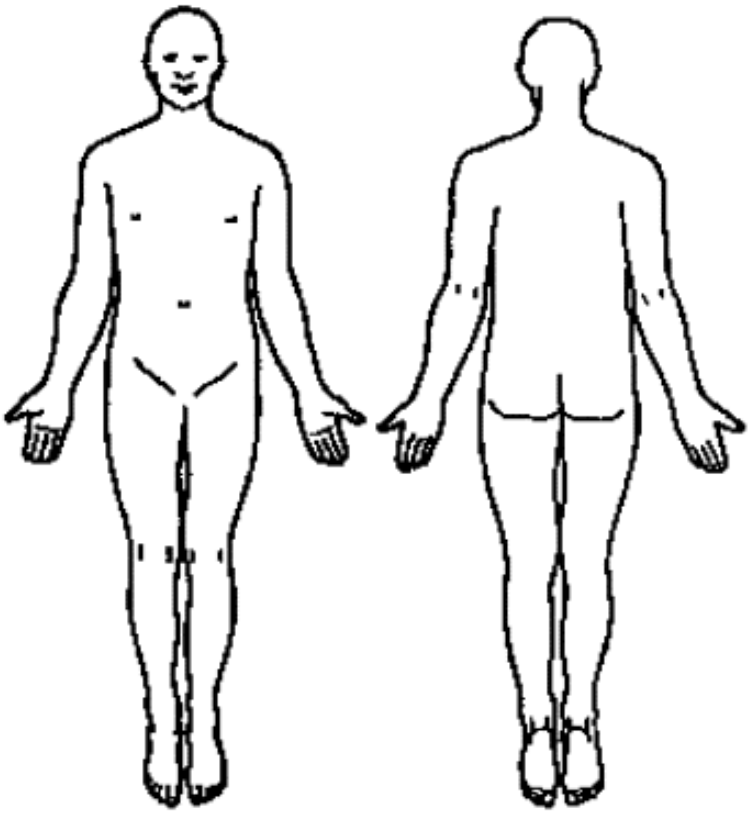
Do you experience limitations as a result of the accident? *(check all that apply)*

□ No	□ Standing	□ Walking
□ Sleeping	□ Driving	□ Lifting
□ Sitting	□ Typing	□ Other _____

What activities aggravate your condition(s)? _____
_____

PAIN LOCATION:

Please mark the location(s) of your symptoms on the diagrams below using the following letters:
Pain (X) Cramping (C) Tingling (T) Soreness (S) Burning (B) Numbness (N) Weakness (W)



Patient's Name: _____

Please check all symptoms that relate exclusively to your accident:

HEAD
- □ Headache
  - □ Entire head
  - □ Back of head
  - □ Forehead
  - □ Temples
  - □ Migraine
- □ Head feels heavy
- □ Loss of memory
- □ Light headedness
- □ Fainting
- □ Light bothers eyes
- □ Blurred vision
- □ Double vision
- □ Loss of vision
- □ Loss of taste
- □ Loss of balance
- □ Loss of hearing
- □ Dizziness
- □ Ringing in ears
- □ Pain in ears
- □ Buzzing in ears

NECK
- □ Neck pain with movement
  - □ Forward
  - □ Backward
  - □ Turning to right
  - □ Turning to left
  - □ Bending to right
  - □ Bending to left
- □ Pinched nerve in neck
- □ Neck feels out of place
- □ Muscle spasms in neck
- □ Grinding sound in neck
- □ Popping sound in neck
- □ Arthritis in neck

CHEST
- □ General chest pain
- □ Shortness of breath
- □ Pain around ribs
- □ Breast pain
- □ Dimpled/orange peel breast
- □ Irregular heartbeat

ARMS & HANDS
- □ Pain in upper arm(s)
- □ Pain in elbow(s)
- □ Aggravated pain with movement
- □ Tennis elbow
- □ Pain in forearm
- □ Pain in hand(s)
- □ Spain in finger(s)
- □ Sensation of pins and needles in arm(s)
- □ Sensation of pins and needles in finger(s)
- □ Numbness in arm(s) (L) (R)
- □ Numbness in finger(s) (L) (R)
- □ Fingers go to sleep
- □ Swollen joints in finger(s)
- □ Sore joints in finger(s)
- □ Arthritis in finger(s)
- □ Loss of grip strength

SHOULDERS
- □ Pain in shoulder joint(s) (L) (R)
- □ Pain across shoulders
- □ Bursitis (L) (R)
- □ Arthritis (L) (R)
- □ Can't raise arm
  - □ Above shoulder level
  - □ Over head
- □ Tension in shoulders
- □ Pinched nerve in shoulders

MID-BACK
- □ General mid-back pain
  - □ Location: _____
- □ Pain between shoulder blades
- □ Sharp stabbing pain
- □ Dull ache
- □ Pain from front to back
- □ Muscle spasms
- □ Pain in kidney area

ABDOMEN
- □ Nervous stomach
- □ Nausea
- □ Gas
- □ Constipation
- □ Diarrhea
- □ Hemorrhoids

LOW BACK
- □ General low back pain
  - □ Upper lumbar
  - □ Lower lumbar
  - □ Sacroiliac
- □ Pain is worse when:
  - □ Sitting
  - □ Standing
  - □ Working
  - □ Lifting
  - □ Stooping
  - □ Bending
  - □ Coughing
  - □ Lying down
  - □ Walking
- □ Slipped disc
- □ Feels out of place
- □ Muscle spasms
- □ Arthritis

HIPS, LEGS, AND FEET
- □ Pain in buttocks (L) (R)
- □ Pain in hip joint (L) (R)
- □ Pain down leg (L) (R)
- □ Pain down both legs
- □ Knee pain
  - □ Inside
  - □ Outside
- □ Leg cramps
- □ Cramps in feet (L) (R)
- □ Pins/needles in leg (L) (R)
- □ Numbness of leg (L) (R)
- □ Numbness of feet (L) (R)
- □ Numbness of toes (L) (R)
- □ Feet feel cold
- □ Swollen ankles (L) (R)
- □ Swollen ankles (L) (R

Patient's Name: _____

REVIEW OF CURRENT SYSTEMS: Please check any that apply.

□ Recent or sudden weight loss, fever, chills, weakness, or fatigue
□ Recently or currently enlarged lymph nodes
□ Recent vision loss, blurred vision, double vision, or yellow sclera
□ Recent hearing loss, sneezing, or congestion
□ Recent and unexplained skin rash or itching
□ Recent anemia, bleeding, or sudden and unexplained or excessive bruising
□ Recent shortness of breath, coughing, recurring phlegm, chest pain, pressure, or discomfort, or heart palpitations
□ Recent nausea, vomiting, diarrhea, abdominal pain, or bloody stool
□ Recent burning during urination
□ Recent headaches, dizziness, syncope, paralysis, change in bowel/bladder control, sweating, or cold/heat intolerance
□ Recent nervousness or anxiety while driving
□ Recent sleep loss or disturbance

Please check next to any of the following conditions you have, may have, or have had in the past:

□ Allergies	□ Depression	□ High blood pressure	□ Neuritis
□ Alcoholism	□ Diabetes	□ Irregular periods	□ Pleurisy
□ Anemia	□ Diarrhea	□ Low blood pressure	□ Polio
□ Arteriosclerosis	□ Eczema	□ Malaria	□ Rheumatic Fever
□ Arthritis	□ Emphysema	□ Measles	□ Ringing in ears
□ Asthma	□ Epilepsy	□ Menstrual cramps	□ Sinus problems
□ Back pain	□ Gall Bladder	□ Miscarriage	□ Stroke
□ Cancer	□ Gout	□ Multiple Sclerosis	□ Thyroid
□ Convulsions	□ Headaches/Migraines	□ Mumps	□ Tuberculosis
□ Constipation	□ Heart attack	□ Nervousness	□ Ulcers
□ Cold sores	□ Heart Disease	□ Neck pain	□ Whooping Cough

PRIOR HOSPITALIZATIONS/SURGERY

Hospital/Facility	Reason for Hospitalization/Surgery	Outcome

HIPAA PRIVACY PRACTICES

I have received a copy of the HIPAA Notice of Privacy Practices. I have read and understand my rights as afforded to me under the Health Insurance Portability and Accountability Act (HIPAA). I understand that I may ask questions of the office.

Patient/Guardian's signature: _____ **Date**: _____

ASSIGNMENT OF BENEFITS

I hereby authorize and assign payment of benefits due under terms of any insurance policy or policies that may cover the medical procedure(s) performed at the address provided on any claim form submitted to my insurance carrier(s). I hereby instruct and direct my insurance company to make payment by check made out to Dr. Jas Walia, D.C. I understand and agree that I am financially responsible for charges not covered by the assignment authorization, payment of bills and any deductibles or co-payment/co-insurance as determined by my insurance carrier's contract.

Patient/Guardian's signature: _____ **Date**: _____