STANGER HealthCare
Unlocks Your Potential

Name_____DOB_____ DOA_____

Address_____ Phone_____

Email_____Attorney_____Ins Company_____

□ **Male** □ **Female** **Height** _____ **Weight** _____

Are you: □ Right handed □ Left handed □ Ambidextrous (both)

What is your nationality? _____

What is your Primary Language: _____ **What is your secondary language:** _____

Which language do you feel more comfortable speaking? _____

ACCIDENT DETAILS:

Were you the: □ Driver □ Passenger □ Back Passenger □ Pedestrian (not in car)

Were you wearing seat restraints? □Full lap and shoulder □Lap only □Shoulder only □Not wearing seatbelt

What was your vehicle doing just prior to the accident?

□ Stopped at a red light □ Making a turn □ Going through and intersection □ Changing lanes

□ Other: _____

Traveling at an approximate speed of: _____ **mph**

Who hit who? □ You were struck by another car □ You struck the other car

What type of vehicle struck you? _____

In your own words, please explain how the accident happened: _____

_____

_____

_____

Where was your vehicle impacted? (Check all that apply)

□Front □ Back □ Driver's side □ Passenger's side □ Front Drive's side □ Front Passenger's side

□ Back driver's side □ Back Passenger's side □ Front and Back

Did your vehicle airbags deploy? □ Yes □ No

Did you lose consciousness at the time of accident? □ Yes □ No

Did police arrive? □ Yes □ No **Was a Police Report taken?** □ Yes □ No

Did you receive medical attention at the scene of the accident? □ Yes □ No

Were you transported to the ER? □ Yes □No If yes, by who: _____

Did you seek medical attention after the accident? □ Yes □ No

If yes, where and by whom: _____

Have you seen a Chiropractor since the accident? □ Yes □ No

If yes, what kind of treatment did you have? _____

How many weeks of treatment have you had? _____ How many times a week do you go? _____

How much have you improved since starting treatment? _____%

Were X-rays taken? □Yes □ No Office: _____ **MRI?** □Yes □ No Office: _____

Body part? _____ **Body part?** _____

_____

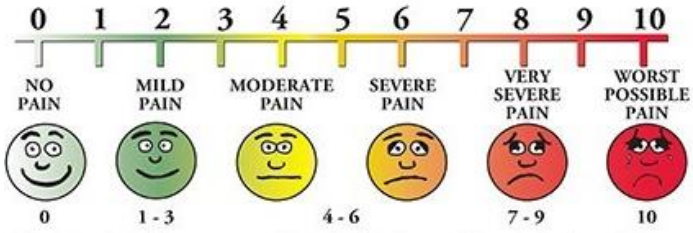
Patient Signature

Body Part: Mark **ONLY** injured parts	**Frequency** **See definitions below:**	**Pain Quality** Dull/Stabbing/Sharp/ Throbbing/Aching	**Severity of Pain** **Using the pain scale below:**	**Pain Radiation:** Does your pain radiate anywhere?	**Numbness/Tingling** Down upper extremities/ lower extremities?
Neck					
Shoulder (L/R)					
Mid Back					
Lower Back					
Knee (L/R)					
Other(s)					

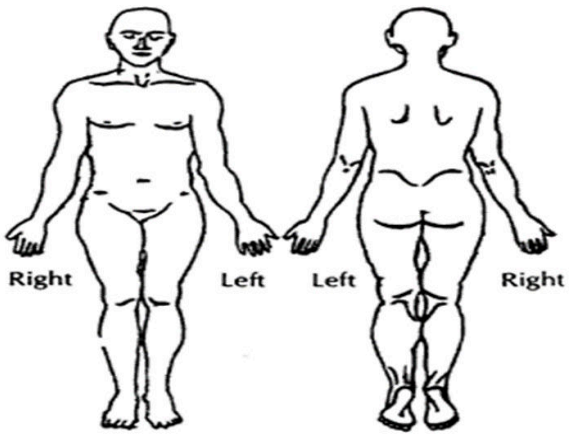
Frequency Definition:

□100% - Continuous □90% - Constant □75% - Frequent □50% - Intermittent □25% - Occasional

↓ Severity of Pain



← Place an X on the body parts you are having pain



Activities of Daily Living:

Sleeping:	□No Difficulties	□Some Difficulties	□Moderate Difficulties	
Bathing:	□No Difficulties	□Some Difficulties	□Moderate Difficulties	□Unable, need assistance
Dressing:	□No Difficulties	□Some Difficulties	□Moderate Difficulties	□Unable, need assistance
Walking:	□No Difficulties	□Some Difficulties	□Moderate Difficulties	□Unable, need assistance
Driving:	□No Difficulties	□Some Difficulties	□Moderate Difficulties	□Unable, need assistance
Cooking:	□No Difficulties	□Some Difficulties	□Moderate Difficulties	□Unable, need assistance

Past Medical History

□Heart Problems □PaceMaker or Stents □High Blood Pressure □Kidney Problems □Thyroid Problems
□Anemia □Diabetes □Seizures □Anxiety/Depression □Osteoporosis □Insomnia □ Stomach/Bowel
□Bleeding Problems/Clotting Problems □High Cholesterol □Headaches □Asthma/Emphysema/Sleep Apnea □ Arthritis
□ Other _____ □Cancer/History of Cancer (what type) _____ □NONE OF THE ABOVE

Have you ever had prior surgeries? □Yes □ No

1.Date_____ Procedures_____ 2.Date_____Procedures_____

3.Date_____ Procedures_____ 4.Date_____ Procedures_____

Have you had any PAST_Accidents ? □Yes □ No **Type of accident** □Motor Vehicle □Slip & Fall □At Work

If yes, **what year?**_____ **what did you injure**?_____

Did you receive treatment for it? □ Yes □ No If yes, What kind of treatment? _____

_____
Patient Signature

Prescription Medications/ Over the Counter/ Vitamins ☐N/A

Name of Medication	Dosage (mg)	Times per day

Are you ALLERGIC to any medications? ☐Yes ☐ No

Medication Allergy	Reaction

Are you ALLERGIC to LATEX or RUBBER? ☐ Yes ☐ No **Reaction:** _____

PERSONAL DETAILS:

What is your occupation? **How long have you been employed there?**

What is your marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Other

Do you have any children? ☐ Yes ☐ No If yes, How many? _____

Are you currently pregnant? ☐ Yes ☐ No If so, how far along are you? _____

Do you consume any tobacco/nicotine? ☐ Yes ☐ No

Do you consume Alcohol? Never Socially Occasionally other_____

Any use of illicit drugs? ☐Yes ☐No If so, What kind of drugs?

REVIEW OF SYSTEMS: Please Check All That Apply

General: ☐Fever ☐Chills ☐Loss of Appetite ☐Sleep Disturbance ☐Unexplained Weight Loss/Gain ☐Night Sweats

EENT: ☐Blurry Vision ☐Double Vision ☐Wear Glasses ☐Sore Throat ☐Nasal congestion/Sinus Issues ☐Hearing Loss

Respiratory: ☐Cough ☐COPD ☐Wheezing ☐Recurrent Upper Respiratory Infections ☐Shortness of Breath

Endocrine: ☐Excessive Thirst ☐Temperature Intolerance ☐Feeling Tired/Fatigue ☐Hot Flashes

Cardiovascular: ☐Chest Pain ☐Irregular Heart Beat ☐Heart Attack ☐Heart Failure ☐Palpitations ☐Varicose Veins

Gastrointestinal: ☐Abdominal Pain ☐Nausea/Vomiting ☐Heartburn ☐Blood in Stool ☐Diarrhea/Constipation ☐Rectal Bleeding

Psychological: ☐Depression ☐Anxiety ☐Trouble Concentrating

Hematologic/Lymphatic: ☐Swollen Glands ☐Blood Clotting ☐Easy Bruising ☐Bleeding Tendencies ☐Prone to infections

Genitourinary: ☐Painful Urination ☐Urinary Frequency ☐Loss of Urinary Control ☐Difficulty Urinating

Skin: ☐Skin Rash ☐Itching ☐Lump or Masses ☐Discoloration of the Skin

Musculoskeletal: ☐Joint Pain ☐Joint Swelling ☐Back Pain ☐Limitation of Motion ☐Neck Pain ☐Pain with Walking

Neurological: ☐Tremors ☐Dizzy Spells ☐Numbness/Tingling ☐Headaches ☐Feeling Weak ☐Convulsion/Seizure

_____

Patient Signature