

SCHILLINGER CHIROPRACTIC GROUP

1050 Northgate Drive
Suite 1
San Rafael, CA 94903
(415) 491-0959

CONFIDENTIAL PATIENT CASE HISTORY

Driver's License _____

E-mail: _____

Name: _____ Home Phone () _____

Home Address _____ City _____ St _____ Zip _____

Mailing Address _____ City _____ St _____ Zip _____

Soc. Sec. No. _____ Age _____ Date of Birth _____ Marital Status S M W D

Occupation _____ Employer _____ Work Phone () _____

How many children? _____ Names (ages) _____

Name of Spouse _____ Spouse's Occupation _____

Spouse's Employer _____ Spouse's Work Phone () _____

Name of Emergency Contact _____ Phone () _____

Was your condition caused by: Auto Accident Work Injury Other _____

Whom may we thank for referring you to our office? _____

General Insurance: Name of Group/Individual Health Insurance: Please give us your card for copying.

Personal Injury:

Insurance carrier of the vehicle you were in _____ Policy No. _____

Does policy have med pay? _____ Policy Limits _____

Claim Number _____ Agent's Name _____ Phone Number _____

Insurance carrier of the other vehicle _____ Policy No. _____

Agent's Name _____ Phone No. _____ Claim No. _____

Your group/individual health insurance name _____

Policy Number _____ Group Number _____ Have you retained an attorney? Yes / No

Attorney's name _____ Attorney's phone number _____

PAYMENT IS EXPECTED AT TIME OF VISIT

I understand and agree that Health and Accident Insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that the Schillinger Chiropractic Group will prepare necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Schillinger Chiropractic Group will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I will be paying for today's services by: Cash Check Visa/MC

Signature _____ Today's Date _____

SCHILLINGER CHIROPRACTIC GROUP

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Name _____ Today's Date _____

Date of Accident _____ Time _____ AM/PM

Were you: Driver Passenger Front Seat Back Seat

Number of people in your vehicle _____ Number of people in other vehicle _____ Number of cars involved _____

Location of accident _____ Closest bisecting street/town _____

Who owns the car? _____ Year and model of car _____

Visibility at time of accident: Poor Fair Good Other _____

Where was the vehicle struck: Right Left Rear Front Side Car rolled over Other _____

Type of accident: Head-on collision Rear-end collision Broad-side collision Front impact (your car rear-ended car in front)

Non-collision (describe) _____ Did you see the accident coming? Yes / No

Did you brace for impact? Yes / No Were seat belts worn? Yes / No Approx. how fast was your car moving? _____

How fast was other car moving? _____ Were you wearing glasses? Yes / No Did they come off due to the accident? Yes / No

Which vehicle is responsible for causing the accident? _____ Is there a police report? Yes / No

POSITION OF BODY AT TIME OF IMPACT:

- Head turned left/right
- Looking back
- Head straight
- Body straight in sitting position
- Body rotated left/right
- Other _____

HEAD/BODY HIT:

- Windshield
- Steering wheel
- Ceiling
- Headrest
- By flying object
- Other _____

Please describe in your own words what happened to you upon impact. Provide details. _____

As a result of the accident were you: Rendered unconscious Dazed Circumstances vague
 Other _____

Could you move all parts of your body? Yes / No If no, what parts and why? _____

Were you able to get out of the vehicle and walk unaided? Yes / No If no, why not? _____

Describe which areas of your body were hurt immediately after the accident _____

How did you spend the evening of the accident? Without event In pain Restless Other _____

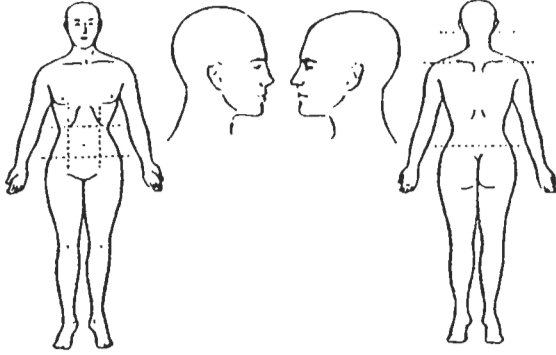
The following day was spend feeling: Worse Better Same Experiencing relief

Which areas were hurting days after the accident? _____

CHECK SYMPTOMS APPARENT SINCE THE ACCIDENT:

- | | | | |
|--------------------------------------------------|----------------------------------------------|----------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Neck pain/stiffness | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Mid-back pain | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Cold feet | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Anxious |
| <input type="checkbox"/> Eyes sensitive | <input type="checkbox"/> Tension | <input type="checkbox"/> Constipation | <input type="checkbox"/> Numbness in toes |
| <input type="checkbox"/> Pain behind the eyes | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Ringing/buzzing in ears | <input type="checkbox"/> Loss of balance | | |

Shade area(s) to indicate location of pain or discomfort.



Indicate your ability to perform the following activities as a result of this injury using codes:

N - Normal, L - Limited, D - Difficult, P - Painful, U - Unable

- | | |
|--------------------------------------|---------------------|
| _____ Walking short distance | _____ Climbing |
| _____ Standing for more than 1 hour | _____ Kneeling |
| _____ Sitting at table | _____ Balancing |
| _____ Lying on back | _____ Dressing self |
| _____ Lying flat on stomach | _____ Sleeping |
| _____ Lying on side with knees bent | _____ Stooping |
| _____ Bending over forward | _____ Gripping |
| _____ Coughing or sneezing | _____ Pushing |
| _____ Getting into or out of car | _____ Pulling |
| _____ Bending forward to brush teeth | _____ Reaching |
| _____ Turning over in bed | _____ Sex activity |

Check proper square:

- Symptoms are WORSE in AM, Mid-day, PM
 Symptoms are BETTER in AM, Mid-day, PM

Did you have any physical complaints BEFORE THE ACCIDENT? Yes/No If yes, describe in detail: _____

Do you have any congenital (from birth) factors which relate to this problem? Yes/No If yes, please describe: _____

Have you ever been involved in an accident before? (Motor vehicle, slip and fall, work-related, etc.) Yes/No If yes, please describe: including date(s), type(s) of accidents, injury(ies) received, and what health care you received. _____

Have you ever had Chiropractic Care? Yes No Doctor's Name _____

What conditions were treated by the previous Chiropractor? _____

Have you been treated for any other health conditions by a physician? Yes No

If yes, please describe _____

What medications or drugs are you taking (not related to this injury)? _____

Date of last physical examination? _____

What operations have you had? Please include dates _____

Did you seek medical help before coming to this office? Yes/No If yes, how did you get there?

- Someone else drove me Drove myself Police Ambulance Other _____

Name of hospitals or clinics where you were treated prior to treatment in our office _____

Name of treating doctor(s) _____ Were you examined? Yes/No

Were x-rays taken? Yes/No If yes, of what area? _____

Were other tests administered (lab, MRI, etc.)? _____ What were the results? _____

What treatment was given? _____

Were you prescribed any drugs or medication? Yes/No If yes, what? _____

Did you take them? Yes/No Were they effective? Yes/No

Have you missed any time at work? Yes/No If yes, full time off from _____ to _____ part time off from _____ to _____

Have you been able to return to work since? Yes/No

WORK ACTIVITIES — On the job, I perform the following activities:

On the job, I lift:

- | | | | | |
|-------------------------------------|------------------------------------------|-----------------------------------------------------|----------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Bend/Stoop | <input type="checkbox"/> Crouch | <input type="checkbox"/> Reach above shoulder level | <input type="checkbox"/> Up to 10 lbs. | <input type="checkbox"/> 35 to 50 lbs. |
| <input type="checkbox"/> Squat | <input type="checkbox"/> Kneel | <input type="checkbox"/> Sitting | <input type="checkbox"/> 11 to 24 lbs. | <input type="checkbox"/> 51 to 74 lbs. |
| <input type="checkbox"/> Crawl | <input type="checkbox"/> Balancing | | <input type="checkbox"/> 25 to 34 lbs. | <input type="checkbox"/> 75 to 100 lbs. |
| <input type="checkbox"/> Climb | <input type="checkbox"/> Pushing/Pulling | | | |

Describe any job activities not listed above: _____