SCHILLINGER CHIROPRACTIC GROUP
119 A Paul Drive
San Rafael, CA 94903
(415) 491-0959

Driver's License _____

CONFIDENTIAL PATIENT CASE HISTORY

_____ E-mail:

Name: _____) _____ ome 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 i _____ 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_____

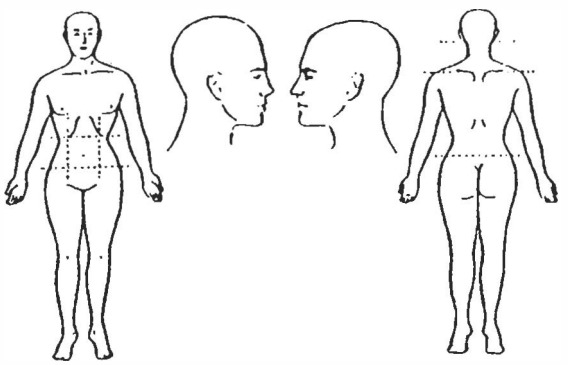
The following day was spend feeling: ☐ Worse ☐ Better ☐ Same ☐ Experiencing relief

Which areas were hurting days after the accident?_____

CHECK SYMPTOMS APPARENT **SINCE** THE ACCIDENT:

☐ Headache	☐ Loss of smell	☐ Numbness in fingers	☐ Chest pain
☐ Neck pain/stiffness	☐ Loss of taste	☐ Cold hands	☐ Nervousness
☐ Mid-back pain	☐ Loss of memory	☐ Cold feet	☐ Cold sweats
☐ Low back pain	☐ Fatigue	☐ Diarrhea	☐ Anxious
☐ Eyes sensitive	☐ Tension	☐ Constipation	☐ Numbness in toes
☐ Pain behind the eyes	☐ Shortness of Breath	☐ Irritability	☐ Sleeping problems
☐ Dizziness	☐ Depression	☐ Fainting	☐ Other_____
☐ Ringing/buzzing in ears	☐ 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:

☐ Bend/Stoop	☐ Crouch	☐ Reach above shoulder level	☐ Sitting
☐ Squat	☐ Kneel		
☐ Crawl	☐ Balancing		
☐ Climb	☐ Pushing/Pulling		

On the job, I lift:

☐ Up to 10 lbs.	☐ 35 to 50 lbs.
☐ 11 to 24 lbs.	☐ 51 to 74 lbs.
☐ 25 to 34 lbs.	☐ 75 to 100 lbs.

Describe any job activities not listed above: _____