



*Inspiring a Health Revolution,
One Family at a Time*

ADULT PATIENT APPLICATION FORM:
MOTOR VEHICLE COLLISION

DATE OF COLLISION/ INJURY: ___/___/___

DATE APPLICATION COMPLETED: ___/___/___

At Whole Family Chiropractic, we are committed to providing our patients with the comprehensive and necessary care and treatment that will support healthy recovery, rapid relief and preventative wellness following injuries sustained in a motor vehicle trauma. We are a very unique health care team specializing in researched, evidence-based, spinal adjusting and postural rehabilitation that has helped many conditions related to motor vehicle trauma to resolve without residual chronic and lifelong health problems.

As a result of this specialized approach we may not accept you as a patient until we are absolutely certain that we know the cause of your condition, determine the extent of the tissue damage related to the trauma you incurred, that we can perform the necessary tests to establish the optimal program of rehabilitation for you, and that we are completely confident that we can help you recover your health. Please know that if we do accept you as a patient, we will then make specific recommendations based upon our understanding of the problem and the recognition that your health will become your top priority.

Thank you again for applying as a patient in our clinic.

Please fill out the following information thoroughly so that your doctor can let you know if you are a case that we can accept. In the process, feel free to ask any questions if you need assistance.

Welcome to our clinic it is our pleasure to serve you and your family!

Dr. Ryan Dachowski, DC & Dr. Jessica Dachowski, DC, DICCP

PATIENT APPLICATION SURVEY

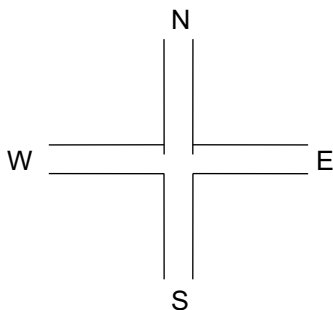
First Name: _____ Mid. Initial: _____ Last Name: _____ (Age) _____ Gender **M F**
Home Address: _____ Home Phone: () _____
City, State, Zip: _____ Work Phone: () _____
Email Address: _____ Cell Phone: () _____
Birth Date: ____/____/____ Social Security #: ____-____-____ Marital Status: **Single Married Divorced Widowed**
Names of Children: _____ Ages: _____ **Natural C-Sect Other**
Employed at time of Collision? **YES NO** Occupation: _____ Employer: _____
Unemployed due to Collision? **YES NO** Type of Work: **Office/ Clerical Light Labor Mod. Labor Heavy Labor**
Spouse's Name: _____ Work Phone: () _____ Cell Phone: () _____
Spouse's Employer: _____ Occupation: _____
How do you prefer to be contacted by the office: **Phone Cell Email** Race: _____ Nickname: _____
Who shall we call in case of emergency: First Name: _____ Last Name: _____
Relationship: _____ Home/ Cell Phone () _____ Work Phone: () _____

AUTOMOBILE COLLISION HISTORY

*All questions must be answered prior to your appointment so that our doctors have the best impression in regards to your injury. **Please answer ALL questions completely**, by circling a YES or NO, and adding a description where necessary. Do not hesitate to ask our staff for help if you may think that you need it. We are here to serve you.*

Do you have an Attorney or Legal Representation: **YES NO** Who: _____ Phone #: _____

PLEASE ILLUSTRATE THE COLLISION & PROVIDE A DESCRIPTION OF THE EVENT(S) IN THE LINES PROVIDED:



Date of Collision: _____ Time of Collision: _____ **AM or PM** Was the collision on the job? **YES NO**
Were you Driving at time of collision? **YES NO** If **NO**, were you a passenger in the: **Front Middle Rear**
Were you on the: **RIGHT Side** or **LEFT Side** of the vehicle and were you still in the same seat after impact? **YES NO**
*** If the collision involved a motorcycle, were you the: **OPERATOR** or **PASSENGER**?

At the time of impact, what was your head position? **FORWARD** - **LEFT** ____° **RIGHT** ____° **UP** ____° **DOWN** ____°
At the time of impact, what was your body position? **FORWARD NEUTRAL LEANING LEFT / RIGHT OTHER**
At the time of impact, where were your hands?: **ONE ON WHEEL TWO ON WHEEL OTHER: _____**

Was it your vehicle that was involved in the collision? **YES NO** If **NO**, who is the vehicle owner? _____

WERE YOU AWARE OF THE IMPENDING COLLISION?: **YES NO**

DID YOU 'BRACE' FOR IMPACT?: **YES NO**

OTHER OCCUPANT(S) DESCRIPTION:

Were there other **ADULTS** in the vehicle with you: **YES NO**

Name: _____ Age: _____ Relation: _____
Name: _____ Age: _____ Relation: _____
Name: _____ Age: _____ Relation: _____

Were there any **INFANTS, TODDLERS, CHILDREN** or **YOUNG ADULTS** in the vehicle with you? **YES NO**

Name: _____ Age: _____ Relation: _____
Name: _____ Age: _____ Relation: _____
Name: _____ Age: _____ Relation: _____

Type of Child Car Restraint: **NONE REAR FACING 5-POINT HARNESS BOOSTER SEAT OTHER: _____**

VEHICLE MOTION(S) DESCRIPTION:

Was your vehicle stopped at the time of impact? **YES NO**
If **YES**, was the driver's foot also on the brake? **YES NO DON'T KNOW**
If **NO**, then estimate the speed of the vehicle you were in: _____mph **DON'T KNOW**
What was the posted speed limit?: _____mph **DON'T KNOW**

If your vehicle was moving at the time of impact, was it:
Slowing Down? **YES NO DON'T KNOW**
Accelerating? **YES NO DON'T KNOW**
Traveling at a steady rate of speed? **YES NO DON'T KNOW**

Was the other vehicle stopped at the time of impact? **YES NO DON'T KNOW**
If **YES**, was the driver's foot also on the brake? **YES NO DON'T KNOW**
If **NO**, then estimate the speed of the other vehicle: _____mph **DON'T KNOW**

If the other vehicle was moving at the time of impact, was it:
Slowing Down? **YES NO DON'T KNOW**
Accelerating? **YES NO DON'T KNOW**
Traveling at a steady rate of speed? **YES NO DON'T KNOW**

SEAT/ SEAT BELT DESCRIPTION:

Was the seat back adjustment altered by the collision?: **YES NO DON'T KNOW**
Was the seat broken in the collision?: **YES NO DON'T KNOW**
Were you wearing a lap belt?: **YES NO DON'T KNOW**
Was the shoulder harness on?: **YES NO DON'T KNOW**
Did you receive any injury or bruise from the seat belt/ shoulder harness?: **YES NO**
If YES, then describe the injury: _____

HEAD RESTRAINT GEOMETRY:

How far is the top of the headrest or seatback from the top of your head: _____inches. **ABOVE HEAD** or **BELOW HEAD**
Describe Head Restraint Type: **NONE INTEGRAL TYPE ADJUSTABLE DON'T KNOW**
***If the head restraint is Adjustable, was it altered by the collision? **YES NO**

EXTERNAL ENVIORNMENTAL CONDITIONS:

Describe the Time of Day: **DAYLIGHT NIGHT DUSK DAWN**
Describe the Road Conditions: **DRY DAMP WET SNOW ICE OTHER: _____**
Describe the Type of Road: **TWO LANE FOUR LANE GRAVEL TAR**
Describe Where the Collision Occurred: **STOP SIGN TRAFFIC LIGHT INTERSECTION HIGHWAY**

INTERNAL ENVIRONMENTAL CONDITIONS:

Were you tired? **YES NO** Were you awake? **YES NO**
Were you driving under the influence of Alcohol? **YES NO**
Were you driving under the influence of Prescription Medications? **YES NO**

How long had you been in the vehicle? _____ **minutes or hours** Where were you prior to the collision? _____

VEHICLE/ PROPERTY / OCCUPANT DAMAGE SUMMARY:

What type of vehicle were you driving? **MAKE:** _____ **MODEL:** _____ **YEAR:** _____

What condition was your vehicle in prior to the collision? _____

Was there damage to your vehicle? **YES NO** Which area of your vehicle was damaged? **FRONT / REAR** and **LEFT / RIGHT**

Describe the damage that was done to your vehicle? *(Please provide the doctor with any pictures that you have)*

INSIDE: _____

OUTSIDE: _____

OTHER: _____

Were there other vehicles involved in the collision? **YES NO** **If YES, how many were involved?** _____

What other type of vehicle was involved in the collision? **CAR TRUCK MOTORCYCLE**

Describe the Size and type: _____

Was the other vehicle moving during the collision? **YES NO DON'T KNOW**

Was there damage to the other vehicle? **YES NO** What part of the vehicle was damaged? **FRONT / BACK** and **LEFT / RIGHT**

INSIDE: _____

OUTSIDE: _____

Do you have pictures of the involved vehicle(s)? **YES NO**

What is the estimated cost damage to the vehicle you were in? \$ _____

Were any of the following parts of your vehicle damaged during the collision?

WINDSHIELD RIGHT/LEFT SIDE WINDOWS STEERING WHEEL

OTHER _____

Did your vehicle strike anything else? **YES NO**

If YES, what? ANOTHER VEHICLE SIGN/ POST TREE/ WALL BRIDGE BARRIER PERSON

OTHER _____

Did your vehicle go off the road? **YES NO**

If so: **Into an Embankment a Ditch** How Deep? _____

Did your head impact any part of the automobile? **YES NO DON'T KNOW**

Did your airbag release? **YES NO DON'T KNOW**

Were you hurt by your airbag? **YES NO DON'T KNOW** Where: _____

Did you lose consciousness (black out) on impact? **YES NO DON'T KNOW** How long: _____

Did you experience a flash of light/ explosion in your head? **YES NO DON'T KNOW**

Do you remember the impact? **YES NO DON'T KNOW**

Does it bother you to ride in a car now? **YES NO DON'T KNOW**

If YES, as a: DRIVER PASSENGER

Have you had any time loss from work? **YES NO** How Long? _____

Have you had any outside help? **YES NO**

POLICE REPORTS:

Was a police report filed? **YES NO DON'T KNOW** By Police of: **City** _____ **County** _____ **State** _____

Who was ticketed? _____

For what? _____

Please provide this clinic with a copy of the report as soon as possible.

GENERAL SYMPTOMS:

Did you hit any part of your body during the collision (head or chest on steering wheel or dash board)? **YES NO**

If Yes, which part and how? _____

Did you become: **CONFUSED DISORIENTED LIGHT-HEADED DIZZY NAUSEOUS BLURRED VISION EAR-RINGING**

Where you bleeding at the time of the accident? **YES NO** Where? _____

Do you have bruises from this accident? **YES NO** Where? _____

Do you still have any symptoms? **YES NO** Explain: _____

Have you ever been injured in a similar manner? **YES NO** Explain: _____

Are you currently suffering from any of the following? **Restlessness Irritability Poor Concentration Pain
Memory Loss Insomnia Increased Stress Numbness
Extremity/ Limb Pain, Where: _____**

Did you go to a hospital? **YES NO** If YES, which hospital? _____

How did you get to the hospital? **AMBULANCE FRIEND/ FAMILY SELF OTHER**

Did the hospital perform imaging studies? **YES NO** Which ones: **XRAY MRI CT OTHER: _____**

Results: _____

What did the hospital do for your injuries? **CERVICAL COLLAR ICE MEDICATIONS LAB WORK OTHER**

Did you receive care from any other medical professional? **YES NO** Name? _____

What type of care were you given and for how long? _____

I hereby state, that the above information in regards to the collision that I incurred, is accurate and true to the best of my knowledge. I am aware that copies of any police/ crash reports would greatly assist in my treatment, and that it is my responsibility to furnish any such reports to this office.

AUTOMOTIVE INSURANCE INFORMATION

Insurance Company Name: _____

Carrier Address: _____ City, State, Zip: _____

Insured Person First Name: _____ M. Initial: ___ Last Name: _____

Relationship to Insured: _____ Home Address: _____ Home Phone: () _____

City, State, Zip: _____ Work Phone: () _____

Email Address: _____ Cell Phone: () _____

Insured Birth Date: ___ / ___ / ___ Social Security #: ___ - ___ - ___ Gender: M F

Insurance ID #: _____ Group #: _____ Group Name: _____

MEDICAL INSURANCE INFORMATION

Insurance Company Name: _____

Carrier Address: _____ City, State, Zip: _____

Insured Person First Name: _____ M. Initial: ___ Last Name: _____

Relationship to Insured: _____ Home Address: _____ Home Phone: () _____

City, State, Zip: _____ Work Phone: () _____

Email Address: _____ Cell Phone: () _____

Insured Birth Date: ___ / ___ / ___ Social Security #: ___ - ___ - ___ Gender: M F

Insurance ID #: _____ Group #: _____ Group Name: _____

HEALTH CONDITIONS

Your spine is the foundation of health and core strength in your body. Research demonstrates that shifts in the vertebra or regional displacements of the spine will spread and ultimately cause weakness and distortion to all of the areas of the spine. These distortions are reflected in abnormal posture positions. Evidence demonstrates that abnormal posture leads to chronic pain, disease and possibly a shortened life span. Please answer the following questions accurately so we may determine the full extent of your condition and identify any associated risk factors.

PURPOSE OF THIS VISIT *(Please List Each of Your Complaints Separately):*

Main Complaint # 1:

Reason for appointment/ Main complaint: _____ Date it started: ____/____/____

Is this purpose related to an Auto Accident / Work Injury/ Slip/Fall ? **Yes No** If so, when: _____

Did it begin: **Gradually Suddenly Progressive Over Time Recurring/ Off and On Chronic Acute**

Is this the first time you have had this pain? **Yes No** When did the 1st episode occur? _____

How did the current episode of pain/ discomfort occur? _____

What activities aggravate your symptoms? _____

Pain Severity: 10 is the worst pain imaginable, and 0 is no pain. Please indicate your pain over last 2 weeks:

Today _____ Best _____ Worst _____

Is there anything, which has relieved your symptoms? **Yes No** Describe: _____

Type of Pain: **Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting Stabbing Pressure Stiff Sore Pins/Needles**

Numbness/ Tingling (pins and needles): **Yes No** Where & when do you feel this: _____

Does the pain radiate into your: **Shoulder Arm Hand Leg Foot Doesn't Radiate** Is it getting worse? **Yes No**

How often do you experience these symptoms throughout the day? **100% 75% 50% 25% 10% Only with Activity**

Does your complaint(s) interfere with: **Sleep Work Hobbies Exercise Daily Routine** Explain: _____

Who have you seen for this? _____ What did they do? _____

On a scale of **0 (No Improvement) – 10 (Full Improvement)** How did you respond? _____

Complaint # 2 (If applicable)

Reason for appointment/ Main complaint: _____ Date it started: ____/____/____

Is this purpose related to an Auto Accident / Work Injury/ Slip/Fall ? **Yes No** If so, when: _____

Did it begin: **Gradually Suddenly Progressive Over Time Recurring/ Off and On Chronic Acute**

Is this the first time you have had this pain? **Yes No** When did the 1st episode occur? _____

How did the current episode of pain/ discomfort occur? _____

What activities aggravate your symptoms? _____

Pain Severity: 10 is the worst pain imaginable, and 0 is no pain. Please indicate your pain over last 2 weeks:

Today _____ Best _____ Worst _____

Is there anything, which has relieved your symptoms? **Yes No** Describe: _____

Type of Pain: **Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting Stabbing Pressure Stiff Sore Pins/Needles**

Numbness/ Tingling (pins and needles): **Yes No** Where & when do you feel this: _____

Does the pain radiate into your: **Shoulder Arm Hand Leg Foot Doesn't Radiate** Is it getting worse? **Yes No**

How often do you experience these symptoms throughout the day? **100% 75% 50% 25% 10% Only with Activity**

Does your complaint(s) interfere with: **Sleep Work Hobbies Exercise Daily Routine** Explain: _____

Who have you seen for this? _____ What did they do? _____

On a scale of **0 (No Improvement) – 10 (Full Improvement)** How did you respond? _____

Complaint # 3 (If applicable)

Reason for appointment/ Main complaint: _____ Date it started: ____/____/____

Is this purpose related to an Auto Accident / Work Injury/ Slip/Fall ? **Yes No** If so, when: _____

Did it begin: **Gradually Suddenly Progressive Over Time Recurring/ Off and On Chronic Acute**

Is this the first time you have had this pain? **Yes No** When did the 1st episode occur? _____

How did the current episode of pain/ discomfort occur? _____

What activities aggravate your symptoms? _____

Pain Severity: 10 is the worst pain imaginable, and 0 is no pain. Please indicate your pain over last 2 weeks:

Today ____ Best ____ Worst ____

Is there anything, which has relieved your symptoms? **Yes No** Describe: _____

Type of Pain: **Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting Stabbing Pressure Stiff Sore Pins/Needles**

Numbness/ Tingling (pins and needles): **Yes No** Where & when do you feel this: _____

Does the pain radiate into your: **Shoulder Arm Hand Leg Foot Doesn't Radiate** Is it getting worse? **Yes No**

How often do you experience these symptoms throughout the day? **100% 75% 50% 25% 10% Only with Activity**

Does your complaint(s) interfere with: **Sleep Work Hobbies Exercise Daily Routine** Explain: _____

Who have you seen for this? _____ What did they do? _____

On a scale of **0 (No Improvement) – 10 (Full Improvement)** How did you respond? _____

GENERAL MEDICAL HISTORY

Who is your Primary Care Physician (PCP)? _____ Specialty: _____

Last Visit Date: ____/____/____ Reason for visit: _____ What did they do? _____

On a scale of **0 (No Improvement) – 10 (Full Improvement)** How did you respond? _____

Secondary Physician: _____ Specialty: _____ Hospital: _____

Last Visit Date: ____/____/____ Reason for visit: _____ What did they do? _____

On a scale of **0 (No Improvement) – 10 (Full Improvement)** How did you respond? _____

Has you ever been to one of the following: Nutritionist____ Homeopath/ Naturopath____ Physical Therapist____

Last Visit Date: ____/____/____ Reason for visit: _____ What did they do? _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a chiropractor before? **Yes No** Who? _____ When? _____

Reason for visits: _____

On a scale of **0 (No Improvement) – 10 (Full Improvement)** How did you respond? _____

Did your previous chiropractor take "Before and After" X-Rays **Yes No** Only "Before" X-Rays **Only "Before" X-Rays No X-rays**

Are you aware that your posture determines your health or were you ever told by them that it can? **Yes No**

Are you aware of any of your poor posture habits or did they make you aware of any? **Yes No**

Explain: _____

Are you aware of any poor posture habits in your spouse or children? **Yes No**

Explain: _____

The most common postural weakness is **FORWARD HEAD SYNDROME** (head and neck starting to bend forward progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse effects on your overall health. **Have you ever been told, or felt like, you carry your head forward, have a rounding of your shoulders, or are developing a "hump" at the base of your neck?** **Yes No**

HEALTH REVIEW OF YOUR BODY SYSTEMS (Check all that Apply)

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebra in your spine. When these spinal bones are twisted or shifted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. **These misalignments are called SUBLUXATIONS (sub-lux-a-shuns). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your organs and overall health.** The most common and detrimental postural distortion is called FORWARD HEAD SYNDROME (a “hunched forward” posture starting in the neck and progressively moving down your spine weakening the entire body).

CERVICAL SPINE (NECK)

Postural distortions from subluxations, (*resulting from Forward Head Syndrome, Scoliosis, etc*), in your neck will weaken the nerves in your arms, hands, and organs of the head and neck for example, thereby affecting these parts of your body.

Please indicate (N) = Now, (P) = Past, next to all conditions you have experienced or both if applicable

- | | | |
|---|--|---|
| <input type="checkbox"/> Neck Pain / Pain in Head/ Face | <input type="checkbox"/> Headaches/ Migraines | <input type="checkbox"/> Sinus Conditions/ Ear Infections |
| <input type="checkbox"/> Pain into Shoulders/ Arms/ Hands | <input type="checkbox"/> Dizziness/ Vertigo | <input type="checkbox"/> Allergies/ Hay Fever |
| <input type="checkbox"/> Numbness/ Tingling in Shoulders/ Arms/ Hands | <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> Recurrent Colds/ Flu |
| <input type="checkbox"/> Coldness in Shoulders/ Arms/ Hands | <input type="checkbox"/> Hearing Disturbances | <input type="checkbox"/> Low Energy/ Fatigue |
| <input type="checkbox"/> Weakness in Shoulders/ Arms/ Hands | <input type="checkbox"/> Hyper/ Hypothyroidism | <input type="checkbox"/> TMJ Pain/Clicking |
| <input type="checkbox"/> Difficulty Sleeping/ Insomnia | <input type="checkbox"/> Sore Throats | <input type="checkbox"/> Learning Disabilities |
| <input type="checkbox"/> Autoimmune Disease/ Frequent Fever & Chills | <input type="checkbox"/> Frequent Nose Bleeds | <input type="checkbox"/> Hyperactivity/ ADHD/ ADD |
| <input type="checkbox"/> Other (Please Explain) | | |

Explain:

THORACIC SPINE (UPPER BACK)

Postural distortions from subluxations, (*resulting from Forward Head Syndrome, Scoliosis, etc*), in your upper back will weaken the nerves to your upper back, heart, lungs, and thyroid for example, thereby affecting these parts of your body.

Please indicate (N) = Now, (P) = Past, next to all conditions you have experienced or both if applicable

- | | | |
|--|--|--|
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Recurrent Lung Infections/ Bronchitis | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Heart Murmurs/ Palpitations | <input type="checkbox"/> Asthma/ Wheezing | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Tachycardia (Faster Heartbeat) | <input type="checkbox"/> Pain on deep Inspiration/ Expiration | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Gallstones/ Gallbladder Condition | <input type="checkbox"/> High Cholesterol/ Blood Pressure | <input type="checkbox"/> Eczema, Skin Infections/ Rashes |
| <input type="checkbox"/> Other (Please Explain) | | |

Explain:

THORACIC SPINE (MID BACK)

Postural distortions from subluxations, (*resulting from Forward Head Syndrome, Scoliosis, etc*), in your mid-back will weaken the nerves to your pancreas, spleen, intestine, and kidneys for example, thereby affecting these parts of your body.

Please indicate (N) = Now, (P) = Past, next to all conditions you have experienced or both if applicable

- | | | |
|--|--|--|
| <input type="checkbox"/> Mid-back Pain/ Pain between Shoulders | <input type="checkbox"/> Hypo/Hyperglycemia (Low/ High Blood Sugar) | <input type="checkbox"/> Diabetes I / II |
| <input type="checkbox"/> Pain into Ribs/ Chest | <input type="checkbox"/> Lactose Intolerant | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Indigestion/ Heartburn | <input type="checkbox"/> Irritable Bowel Syndrome/ Crohn's Disease/ Celiac Disease | <input type="checkbox"/> Ulcers/ Gastritis |
| <input type="checkbox"/> Nausea/ Abdominal Cramping | <input type="checkbox"/> Tired/ Irritable after eating when you haven't eaten for awhile | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Spleen/ Liver Problems | <input type="checkbox"/> Other (Please Explain) | |

Explain:

LUMBAR SPINE (LOW BACK)

Postural distortions from subluxations, (*resulting from Forward Head Syndrome, Scoliosis, etc*), in your lower back will weaken the nerves to your bladder, colon, reproductive organs, low back, hips, legs, and feet for example thereby affecting these parts of your body.

Please indicate (N) = Now, (P) = Past, next to all conditions your child has experienced or both if applicable

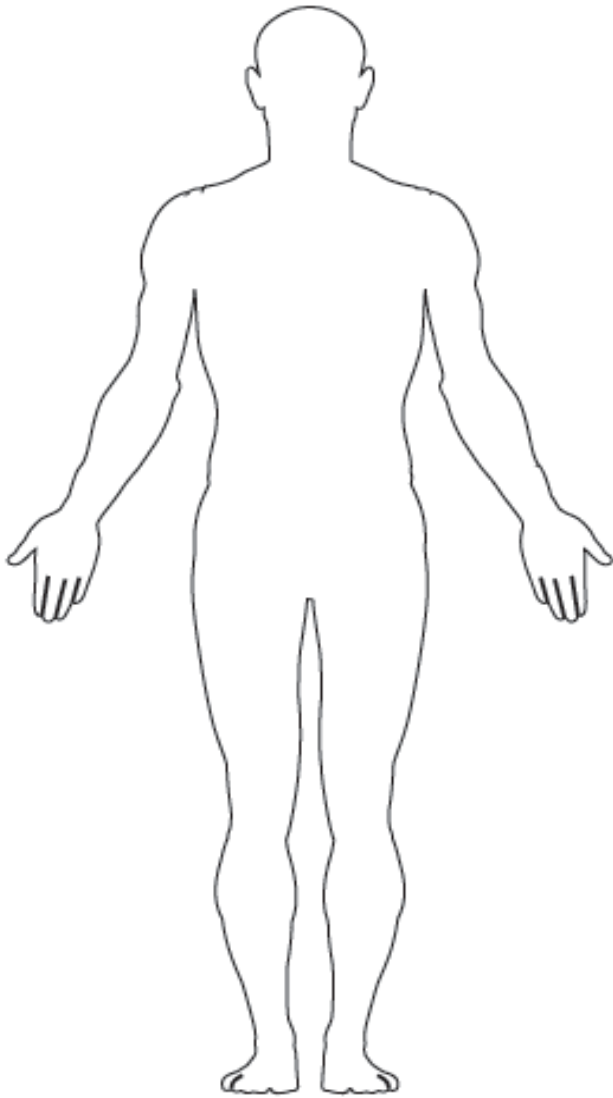
- | | | |
|---|--|--|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Recurrent Bladder Infections | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Numbness in Hips/ Legs/ Feet | <input type="checkbox"/> Difficulty/ Pain with Urination | <input type="checkbox"/> Constipation/ Diarrhea |
| <input type="checkbox"/> Coldness in Hips/ Legs/ Feet | <input type="checkbox"/> Pain into Hips, Legs, Feet | <input type="checkbox"/> Restless Leg Syndrome |
| <input type="checkbox"/> Muscle Cramps in Hips/ Legs/ Feet | <input type="checkbox"/> Increased Gas/ Bloating | <input type="checkbox"/> Menstrual Irregularities/ Cramping / Pain |
| <input type="checkbox"/> Pain with Bowel Movement | <input type="checkbox"/> Abdominal Pain/ Cramping | <input type="checkbox"/> Other (Please Explain) |
| <input type="checkbox"/> Weakness/ Injuries in Hips/ Legs/ Feet | | |

Explain:

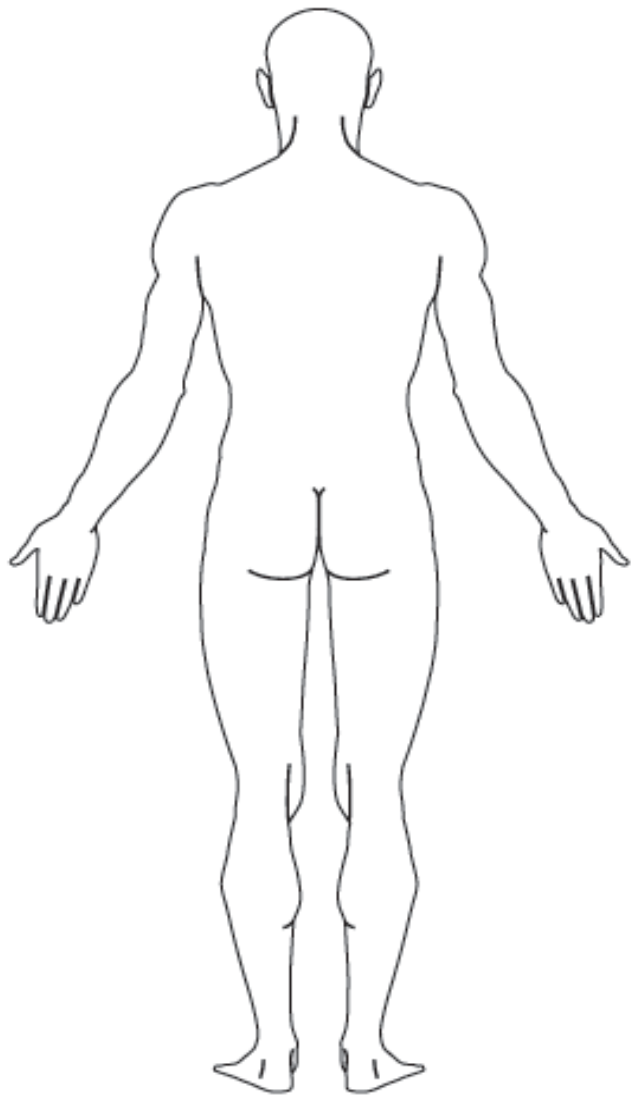
GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms as it relates to the purpose of your visit today

A = ACHE	G = STABBING	N = NUMBNESS	R = THROBBING
B = BURNING	M = SPASMS	T = TINGLING	D = DULL
P = PINS & NEEDLES	F = STIFFNESS	S = SHOOTING	O = OTHER



FRONT



BACK

If you marked "O" for OTHER on any part, please explain: _____

LIFESTYLE HISTORY

Do you exercise? **Yes** **No** How often? **1x** **2x** **3x** **4x** **5x / per week** other: _____

What activities? Run/Jog Walk/ Hike Weight Train Bike Yoga/ Pilates Swim Dance Sports: _____

Do you smoke? **Yes** **No** How much? _____

Recreational/ Illegal Drug Use: **Yes** **No** Describe: _____

Do you drink alcohol? **Yes** **No** How much / week? _____

Do you drink coffee? **Yes** **No** How many cups / day? _____

Do you take any nutritional supplements? **Yes** **No** Which? _____

FAMILY HEALTH HISTORY

Have you or any of your family members ever been diagnosed with the following?

If so, please indicate (Y) = You, (O) = Other family member, next to all conditions or both if applicable

ADD/ ADHD	Allergies/ Hay Fever	Anemia	Appendectomy
Arthritis	Asthma	Bed Wetting	Blood Sugar Problems
Broken Bones/ Fractures	Cancer	Cerebral Palsy	Chicken Pox/ Shingles
Circulatory Problems	Crohn's Disease/ Colitis	Depression	Diabetes
Ear Infections	Eczema/ Rash	Psoriasis/ Lupus	Epilepsy/ Seizures
Fetal Drug Exposure	Food Allergies	Gall Bladder Problems	Headaches
Heart Disease	Heart Murmur	Lyme Disease	Hernia
High Blood Pressure	HIV	Infectious Disease	Influenzae
Kidney Disease	Liver Disease	Lung Disease	Measles/ Mumps
Multiple Sclerosis	Muscular Dystrophy	Metal Implants	Migraines
Neurologic Problems	Osteoporosis	Paralysis	Pleurisy
Pneumonia/ Bronchitis	Polio	Fibromyalgia	Rheumatic Fever
Scoliosis	Sickle Cell Anemia	Sudden Weight Gain/ Loss	Stress
Spina Bifida	Stroke	Thyroid Problems	Tonsillectomy
Tuberculosis	Varicose Veins	Whooping Cough	Other (Please Explain)

SURGERIES, TRAUMAS, MEDICATIONS, ALLERGIES:

Please list all **PAST SURGERIES** performed on you:

Name of Surgery: _____ **Date:** ___/___/___ **Dr:** _____

Name of Surgery: _____ **Date:** ___/___/___ **Dr:** _____

Name of Surgery: _____ **Date:** ___/___/___ **Dr:** _____

Please list all **Previous Accidents/ Falls/ Motor Vehicle Collisions/ Sports Injuries/ Work Comp Injuries** incurred by you:

Incident: _____ **Date:** ___/___/___ **Injury:** _____

List any residual signs and symptoms: _____

List any awards (for property, medical bills, pain/suffering, etc): _____

Incident: _____ **Date:** ___/___/___ **Injury:** _____

List any residual signs and symptoms: _____

List any awards (for property, medical bills, pain/suffering, etc): _____

Incident: _____ **Date:** ___/___/___ **Injury:** _____

List any residual signs and symptoms: _____

List any awards (for property, medical bills, pain/suffering, etc): _____

Please list all **MEDICATIONS** prescribed to you:

Name: _____ **Date Started:** ___/___/___ **Use:** _____

Name: _____ **Date Started:** ___/___/___ **Use:** _____

Name: _____ **Date Started:** ___/___/___ **Use:** _____

Name: _____ **Date Started:** ___/___/___ **Use:** _____

Name: _____ **Date Started:** ___/___/___ **Use:** _____

Please circle all **ALLERGIES** you have been diagnosed with:

FOOD PETS INSECTS MEDICATIONS ENVIORNMENT OTHER Describe: _____

PATEINT GOALS FOR CARE:

____ **Have More Energy and Endurance** ____ **Be Free of Pain** ____ **Sleep Better**

____ **Reduce Stress** ____ **Get Less Colds/ Flus** ____ **Improve Posture**

____ **Reduce Medications/Over the Counters** ____ **Slow Aging** ____ **Burn More Body Fat** ____ **Gain Strength**

____ **Improve Memory/ Focus** ____ **Better Nutrition** ____ **Less Depressed** ____ **Less Angry/ Moody** ____ **Be More Motivated**

____ **Quit Smoking** ____ **Decrease Disease Risk** ____ **Stop Treating "illness" and Create "Wellness" in My Life**

____ **Restore Normal Function to My Body** ____ **Other:** _____

____ **Other:** _____

REFERRAL INFORMATION

Who can we thank for referring you to our office?

Doctor: _____ Friend: _____ Staff Member: _____

Newspaper: _____ Internet: _____ Screening: _____ Signage Facebook/ Social Media Other: _____

ACTIVITIES OF DAILY LIFE: EFFECTS OF CURRENT CONDITIONS ON

PERFORMANCE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Concentrating	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Doing computer Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Gardening	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Playing Sports	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Recreation Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Shoveling	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sleeping	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Watching TV	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Carrying	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dancing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Lifting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Pushing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Rolling Over	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Working	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Climbing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Doing Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Performing Sexual Activity	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Reading	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Running	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform

Sitting to Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform

TERMS OF ACCEPTANCE:

When a person seeks chiropractic and rehabilitation health care services and is accepted for such care, it is essential for both parties to be working towards the same objective. **As a Chiropractic & Physical Medicine Rehabilitation Facility we have one main goal; to detect and correct/ reduce the vertebral subluxations complex.** It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

ADJUSTMENT:

An adjustment is the specific application of forces to facilitate the body’s correction of vertebral subluxation. Our chiropractic method is by specific adjustment of the spine.

HEALTH:

A state of optimal physical, mental, emotional and social well-being, not merely the absence of infirmity, disease or sickness.

VERTERBAL SUBLUXATION:

A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body’s innate ability to express it’s maximum health potential.

We do not offer to diagnose or treat a disease or condition other than vertebral subluxations. Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our only practice objective** is to eliminate a major interference to the expression of the body’s innate wisdom and ability to heal. Our only method is the specific adjustment to correct vertebral subluxations combined with rehabilitation procedures.

NOTE: It is understood and agreed that the amount paid to Whole Family Chiropractic for X-Ray, is for examination only and that the X-Rays will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

AUTHORIZATION OF CARE TO EVALUATE AND TREAT:

I have read and fully understand the terms of acceptance and do hereby authorize and grant permission to the doctors of Whole Family Chiropractic and any designated staff members working under their supervision and instruction, to administer such care that is necessary for my spine and for my particular case/ condition. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy, rehabilitative exercises, passive therapy, diagnostic X-Rays and non-chiropractic procedures including; nutritional intervention, and lifestyle management or any other intervention that is advisable and necessary for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function and overall improvement of my health.

I have had an opportunity to discuss with the doctor of chiropractic assigned to me and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. **I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.** I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and have been informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

Lastly, I clearly understand that if I do not follow the doctor’s specific recommendations at this clinic, that I will not receive the full benefit of the programs offered. Additionally, I recognize that if I terminate the recommended care plan prematurely,

DECLARATION:

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. **The doctor's office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances.** Any monies received will be credited to my account. I certify (for personal insurance purposes only) that this office visit is not related to any personal injury or worker's compensation case that is active or that has not been closed and/or finalized.

Signature of Person Authorizing Care/ Payment: _____

Signature (Parent/ Legal Guardian if Minor)

_____/_____/_____
Date

RAND 36 GENERAL HEALTH SURVEY

- | | | |
|--|--------------------------------------|---|
| 1. In general, would you say your health is:
(Circle one number) | Excellent | 1 |
| | Very Good | 2 |
| | Good | 3 |
| | Fair | 4 |
| | Poor | 5 |
| 2. Compared to one year ago, how would you rate your:
general health right now ? | Much better than one year ago | 1 |
| | Somewhat better than one year ago | 2 |
| | About the same | 3 |
| | Somewhat worse now than one year ago | 4 |
| | Much worse now than one year ago | 5 |

The following questions are about activities that you might perform on a typical day.
Does **your health now limit you** in these activities? If so, how much?

(Circle one Number on each line)	Yes Limited a Lot	Yes Limited A Little	No Not Limited
3. Vigorous Activities , such as running, lifting heavy objects, participating in strenuous sports	1	2	3
4. Moderate Activities , such as moving a table, pushing a vacuum, bowling, or playing golf	1	2	3
5. Lifting or carrying groceries	1	2	3
6. Climbing several flights of stairs	1	2	3
7. Climbing one flight of stairs	1	2	3
8. Bending, kneeling, or stooping	1	2	3
9. Walking more than one mile	1	2	3
10. Walking several blocks	1	2	3
11. Walking one block	1	2	3
12. Bathing or dressing yourself	1	2	3

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities
as a result of your physical health? (Circle one number on each line)

	Yes	No
13. Cut down the amount of time you spend on work or other activities	1	2
14. Accomplish less than you would like	1	2
15. Were limited in the kind of work or other activities	1	2
16. Had difficulty performing the work or other activities (for example, took extra effort)	1	2

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities
as a result of any emotional problems? (Circle one number on each line)

	Yes	No
17. Cut down the amount of time you spend on work or other activities	1	2
18. Accomplish less than you would like	1	2
19. Didn't do work or other activities as carefully as usual	1	2

20. During the past 4 weeks , to what extent has your physical health, or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? (Circle one number)	Not at All Slightly Moderate Quite a bit Good	1 2 3 4 5
21. How much bodily pain have you had during the past 4 weeks : (Circle one number)	None Very Mild Mild Moderate Severe Very Severe	1 2 3 4 5 6
22. During the past 4 weeks , how much did pain interfere with your normal work (including both work outside the home and housework) ? (Circle one number)	Not at all Slightly Moderately Quite a bit Extremely	1 2 3 4 5

These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way that you have been feeling.

How much of the time during the **past 4 weeks**:
(Circle one number on each line)

	ALL of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
23. Did you feel full of pep?	1	2	3	4	5	6
24. Have you been a very nervous person?	1	2	3	4	5	6
25. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
26. Have you felt calm and peaceful?	1	2	3	4	5	6
27. Do you have a lot of energy?	1	2	3	4	5	6
28. Have you felt downhearted and blue?	1	2	3	4	5	6
29. Did you feel worn out?	1	2	3	4	5	6
30. Have you been a happy person?	1	2	3	4	5	6
31. Did you feel tired?	1	2	3	4	5	6
32. During the past 4 weeks , to what extent has your physical health or emotional problems interfered with your normal social activities like visiting with family, friends, relatives, etc? (Circle one number)					All of the time Most of the time Some of the time A little of the time None of the time	1 2 3 4 5

How **TRUE** or **FALSE** is each of the following statements for you?
(Circle one number on each line)

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
33. I seem to get sick a little easier than other people	1	2	3	4	5
34. I am as healthy as anybody I know	1	2	3	4	5
35. I expect my health to get worse	1	2	3	4	5
36. My health is excellent	1	2	3	4	5

