Dr. Williams *Chiropractic Office*

MOTOR VEHICLE CASE HISTORY

PLEASE PRINT

First Name: ______________________________ **M.I.:** ______ **Last Name:** _________________________________

Date Of Accident: _____________________ **Time Of Accident:** _____________ **A.M.** _______ **P.M.** ________

You Were Heading: North _____ **South** ______ **West** ______ **East** ______ **Traveling At** ____________ **M.P.H.**

The Other Motor Vehicle Was Heading: North _____ **South** _____ **West** _____ **East** _____ **At** _____ **M.P.H.**

On (Freeway, Highway Or Street) ____

In The City Of: ____ **In The State Of:** ___________________________

You Were The: Driver _________ **Passenger** ________ **(If You Were The Passenger You Were Sitting In The):**

Front Right Seat _______ **Left Rear Seat (Behind Driver)** ______ **Right Rear Seat (Behind Passenger)** ______

Your Motor Vehicle Was Struck On The: Rear _______ **Front** _______ **Right Side** _______ **Left Side** _______

Did You Receive Medical Attention At The Accident Scene? ____________ **Were You Conscious:** ____________

Did You Go To A Medical Facility/Physician For Treatment After The Accident? ______________ **If Yes, Where**

____

Where Do You Feel Pain? ____

____

____

Is Your Pain: Improving __________ **Same** __________ **Getting Worse** __________ **Other** ___________

____

Do You Have An Attorney? __________ **If Yes – Please Be Advised/Aware Dr. Williams *Chiropractic Office* Does Not Treat Any Motor Vehicle Accident Patient(s) Represented By An Attorney**

HOWEVER

Dr. Williams *Chiropractic Office* Will Treat Motor Vehicle Accident Patient(s) With Medical Payment Motor Vehicle Insurance In Which Dr. Williams *Chiropractic Office* Will Receive Direct Payment From The Patient(s) Medical Payment Insurance Company Or Direct Payment From The Patient(s)!

PATIENT'S – GUARDIAN'S ADDITIONAL NOTE(S)

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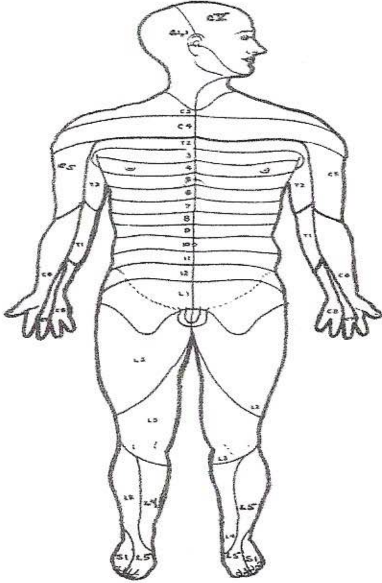
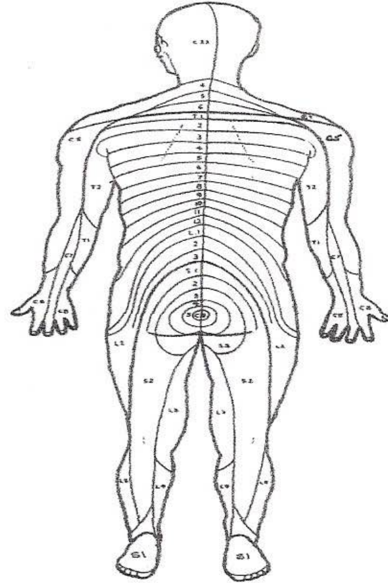
____

Dr. Williams *Chiropractic Office*

Please Mark Area(s) & Type of Pain On The Drawings Using The Codes Listed Below

A-Ache N-Numbness P-Pain S-Soreness ST–Stiffness T-Tingling





In order for this office to properly serve you and help your condition, we need to know which of the following chiropractic treatment plans you desire.

Acute Care aka Aspirin Care ________
I just want the pain to go away.

Rehabilitative Care aka Current Condition Care ________
I want the pain to go away and to correct the problem.

Preventative Care aka Wellness Care ________
I want to have regular chiropractic and spinal care.

Dr. Williams *Chiropractic Office* Financial Policy

I, the patient – guardian, understand Dr. Williams *Chiropractic Office* does not have a contract with my insurance company for chiropractic service(s) rendered therefore I, the patient - guardian, am financially responsible for all x-ray's, braces, orthopedic supports, supplements, vitamins as well as chiropractic service(s) rendered to and payment is due when chiropractic service(s) are rendered!

Date ____/____/____ *Patient's – Guardian's Signature* ____________________________________

Dr. Williams *Chiropractic Office*

DR. WILLIAMS CHIROPRACTIC OFFICE CONSULTATION NOTE(S):

Dr. Williams *Chiropractic Office*
(909) 592-2823

PAIN QUESTIONNAIRE

DATE: ______/______/__________ **NAME:** ____

AREA(S) OF PAIN: ____

1. **Please Indicate Your Usual Level Of Pain During The Past Week!**

   No Pain = 0 1 2 3 4 5 6 7 8 9 10 = Worst Pain Possible

2. **Does Pain, Numbness, Tingling Or Weakness Extend Into Your Back- Arm(s) – Legs?**

   No Pain = 0 1 2 3 4 5 6 7 8 9 10 = Worst Pain Possible

3. **How Would You Rate Your General Health?**

   Good = 0 1 2 3 4 5 6 7 8 9 10 = Not Good At All

4. **If You Had To Spend The Rest Of Your Life With Your Condition As It Is Right Now – How Would You Feel About It?**

   Very Happy = 0 1 2 3 4 5 6 7 8 9 10 = Not Very Happy

5. **How Anxious – Tense – Uptight – Irritable – Fearful – Difficult In Concentrating – Relaxing – Have You Been Feeling During The Past Week?**

   No Tension = 0 1 2 3 4 5 6 7 8 9 10 = Very Tense

6. **How Much Have You Been Able To Control - Reduce – Help – Your Pain – On Your Own During The Past Week?**

   Very Controlled = 0 1 2 3 4 5 6 7 8 9 10 = No Control

7. **Please Indicate How Depressed – Down in The Dumps – Sad – Downhearted – In Low Spirits – Pessimistic Feelings I Have Been Feeling In The Past Week?**

   No Depression = 0 1 2 3 4 5 6 7 8 9 10 = Very Depressed

8. **How Certain Are You That You Will Be Doing Normal Activities Or Working Without Pain In Six (6) Months?**

   Very Certain = 0 1 2 3 4 5 6 7 8 9 10 = Not Certain

9. **Can You State "I Can Do Light Work For An Hour"**

   I Can = 0 1 2 3 4 5 6 7 8 9 10 = No I Cannot

10. **Can You State I Can Sleep At Night."**

    I Sleep All Night = 0 1 2 3 4 5 6 7 8 9 10 = I Cannot Sleep At Night

11. **An Increase In Pain Is An Indication That I Should Stop What I Am Doing Until The Pain Decreases Or Goes Away!**

    No Increase In Pain = 0 1 2 3 4 5 6 7 8 9 10 = I Have A Increase In Pain

12. **Physical Activity Makes My Pain Worse!**

    No = 0 1 2 3 4 5 6 7 8 9 10 = Yes Physical Activity Makes My Pain Worse

13. **I Should Not Do My Normal Activities Including Work With My Present Pain!**

    Able To Do My Normal Activities = 0 1 2 3 4 5 6 7 8 9 10 = Not Able To Do My Normal Activities

Dr. Williams *Chiropractic Office*

PLEASE CHECK ALL PRESENT SYMPTOMS

DATE ____/____/______ **NAME** ____

PRINT FIRST PRINT MIDDLE PRINT LAST

PLEASE CIRCLE RIGHT OR LEFT

HEAD

____ HEADACHES

____ SINUS

____ MIGRAINE HEADACHE

____ HEADACHE ON TOP OF HEAD

____ HEADACHE ON BACK OF HEAD

____ HEADACHE ON FOREHEAD

____ HEADACHE ON SIDE OF HEAD

____ HEAD FEELS HEAVY

____ LIGHT HEADEDNESS

____ DIZZINESS

____ RINGING IN EARS

NECK

____ PAIN IN NECK

____ NECK PAIN WITH MOVEMENT

____ MUSCLE SPASMS

SHOULDERS

____ PAIN IN RIGHT SHOULDER

____ PAIN IN LEFT SHOULDER

____ PAIN ACROSS SHOULDERS

____ UNABLE TO MOVE SHOULDER

____ MUSCLE SPASMS IN SHOULDER

ARMS & HANDS

____ PAIN IN UPPER RIGHT OR LEFT ARM

____ PAIN IN RIGHT OR LEFT ELBOW

____ PAIN IN RIGHT OR LEFT FOREARM

____ PAIN IN RIGHT OR LEFT HAND

____ NUMBNESS IN RIGHT OR LEFT EXTREMITY

MID - BACK

____ MID BACK PAIN

____ DULL PAIN

____ SHARP PAIN

ABDOMEN

____ STOMACH PAIN

____ GAS

____ CONSTIPATION

____ DIARRHEA

____ NAUSEA

____ HEMORRHOIDS

LOWER BACK

____ LOW BACK PAIN

____ LOW BACK PAIN UPON MOVEMENT

____ MUSCLE SPASMS

CHEST

____ CHEST PAIN

____ RADIATING CHEST PAIN

____ SHORTNESS OF BREATH

____ BREAST PAIN RIGHT OR LEFT

LEGS & FEET

____ PAIN IN UPPER RIGHT OR LEFT LEG

____ PAIN IN RIGHT OR LEFT KNEE

____ PAIN IN RIGHT OR LEFT LEG

____ PAIN IN RIGHT OR LEFT ANKLE

____ PAIN IN RIGHT OR LEFT FOOT

NOTES

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