DOUBLE OAK
PHONE (972) 317-3146| FAX (972) 317- 4417
8401 Justin Rd Ste 108, Double Oak, TX 75077

FLOWER MOUND
PHONE (972) 460-4420 | FAX (972) 874-8439
2616 Long Prairie Rd Ste 101, Flower Mound TX 75022

FRISCO
PHONE (972) 460-4420| FAX (469)294-0115
4235 Preston Rd Ste 300 Frisco, TX 75034

Patient Name: _____ **Date:** _____

Date of Accident: _____ **Time of Accident:** _____ **AM/PM**

Please describe the accident in your own words: _____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ L / R Rear Passenger ☐ Pedestrian
Did the police come to the accident site? ☐ Yes ☐ No
Were there any witnesses? ☐ Yes ☐ No
Was a police report filed? ☐ Yes ☐ No

ACCIDENT SITE:

1. Road/Street Name: _____
2. Driving Conditions: ☐Dry ☐Wet ☐Icy ☐Other:_____
3. Which direction were you headed? _____
4. Speed you were traveling: _____

VEHICLE INFORMATION:

1. Make/Model of your vehicle:_____
2. Seatbelt: ☐Yes ☐No
3. Was vehicle equipped with airbags? ☐Yes ☐No
   - Did they inflate properly? ☐Yes☐No
4. Did your seat have a headrest? ☐Yes ☐No
   - If yes, what was the position? ☐Low ☐Mid-position ☐High

OTHER VEHICLE:

1. Make/Model of other vehicle: _____
2. Which direction was the other vehicle heading? _____
3. Speed other vehicle traveling: _____

IMPACT:

1. Did your car impact another vehicle? ☐Yes ☐No
2. Did your car impact another structure? ☐Yes ☐No

If yes to either, please explain: _____
_____

3. Did any part of your body strike anything in the vehicle?

If yes, please explain: _____
_____

4. Was impact from:☐Front ☐Rear ☐Left ☐Right
5. At the time of impact were you looking:
   ☐To the Left ☐To the Right
   ☐Down ☐Up
   ☐Straight Ahead
6. Were both hands on the steering wheel?☐Yes ☐No

If no, which hand was on the wheel? ☐Left ☐Right

7. Was your foot on the brake? If yes, which foot?
   ☐Yes ☐No
   ☐Left ☐Right
8. Were you:
   ☐Surprised by Impact
   ☐Braced for Impact
9. Please describe how you felt immediately after the accident:
   _____

PREVIOUS TREATMENT IF APPLICABLE:

1. Did you go to the hospital? ☐ Yes ☐ No
2. When did you go? ☐ Immediately ☐ Next Day ☐ 2 Days or more after accident
3. How did you get to the hospital? ☐ Ambulance ☐ Private Transportation
4. Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, how long: _____
5. Name of Hospital: _____
6. Diagnosis: _____
7. Treatment Received: _____
8. Radiology Received: _____

Front Desk Initials: _____

MVA Insurance Information

PIP (your personal auto insurance)

Insurance Carrier: _____
Address: _____
Adjuster's Name: _____
Adjuster's Phone Number: _____
Email: _____
Insured: _____
Claim Number: _____

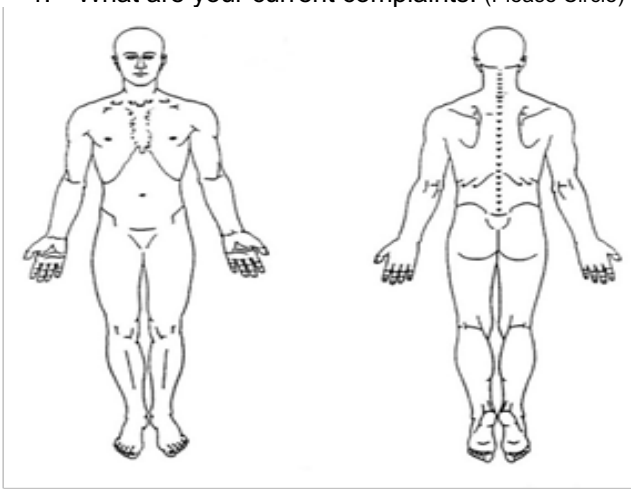
Liability (the auto insurance of the person who hit you)

Insurance Carrier: _____
Address: _____
Adjuster's Name: _____
Adjuster's Phone Number: _____
Email: _____
Insured: _____
Claim Number: _____

Front Desk Initials: _____

Patient Name: _____

1. What are your current complaints: (Please Circle)



2. Describe your symptoms:

☐ Sharp	☐ Prickling	☐ Shooting with Motion
☐ Dull	☐ Itchy	☐ Stabbing with Motion
☐ Diffused	☐ Numbness	☐ Electric with Motion
☐ Achy	☐ Tingling	
☐ Burning	☐ Throbbing	
☐ Shooting	☐ Stabbing	
☐ Stiffness	☐ Sharp with Motion	

3. How long has the pain been going on? _____

Office Use Only

HR: _____ BP: _____/_____

OXG: _____ TEMP: _____

Treatment

☐ **TX1** – Acute/Symptomatic ☐ **TX2** – Rehab/Repair

☐ **TX3** – Stability/Strength ☐ **TX4** – Restorative/Extended

NOTES:

_____

_____

_____

_____

_____

_____

Frequency: _____ X 8 Weeks

Provider Signature:

_____

Current Dx: _____ Onset Date: _____

4. How often do you experience symptoms:
☐ Constant 76-100%
☐ Frequently 51-75%
☐ Occasionally 26-50%
☐ Intermittently 0-25%

5. Are your symptoms getting:
☐ Worse
☐ Same
☐ Better

6. The past **week** my pain has been a (0-10): _____

7. How did your problem begin?

_____

8. Has your pain interfered with any of the following normal activities of daily living? (aggravating factors)

☐ Standing	☐ Sitting
☐ Activity	☐ Lifting
☐ Laying	☐ Work
☐ Travel	☐ Driving
☐ Prolonged Standing	☐ Stooping/Bending
☐ Exercise	☐ Golfing
☐ Movement	☐ Reaching Overhead
☐ Running	☐ Stress
☐ Twisting	☐ Weather Changes
☐ Computer	☐ Working Out
☐ Walking	☐ OTHER: _____

9. What alleviates your symptoms: _____

10. Review of Systems – Mark all that apply

☐ Fatigue	☐ Weight Loss
☐ Weight Gain	☐ Muscle Aches
☐ Seasonal Allergies	☐ Headache
☐ Muscle Weakness	☐ Neck Pain
☐ Upper Back Pain	☐ Mid Back Pain
☐ Low Back Pain	☐ Numbness
☐ Tingling	☐ Abnormal Posture

Front Desk Initials: _____

11. How much has the problem interfered with your work?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

12. How much has the problem interfered with your social activities?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

13. Who else have you seen for your problem?
□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other: _____
□ Massage Therapist □ Physical Therapist □ No one

14. Do you consider this problem to be severe? □ Yes □ Yes, at times □ No

15. Over the past two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than ½ the days	Nearly every day
Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**

16. Females only: When was your last Menstrual period? _____

17. What is your: Height_____ Weight _____ Date of Birth _____
Occupation_____

20. Have you had labs done recently (within last 6 months)? □ Yes □ No
If "Yes", when?_____

21. Have you ever been told you had diabetes or a problem with blood sugar? Yes/No

22. For each of the conditions listed below, place a check in the "Past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "Present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	Kidney Disorders	□	□	**Gastric reflux**
□	□	Neck Pain	□	□	Bladder Infection	□	□	**Irritable Bowel – Syndrome/IBS**
□	□	Upper Back Pain	□	□	Painful Urination			
□	□	Mid-Back Pain	□	□	Loss of Bladder Control	□	□	**Neuropathy**
□	□	Low Back Pain	□	□	Abnormal Weight Loss	□	□	**Weakness**
□	□	Shoulder Pain	□	□	**Abnormal Weight Gain**	□	□	**Fibromyalgia**
□	□	Elbow/Upper Arm	□	□	Loss of Appetite	□	□	**Gout**
□	□	Wrist Pain	□	□	**Abdominal Pain**	□	□	**Sleep apnea**
□	□	Hand Pain	□	□	**Ulcer**	□	□	**Snoring**
□	□	Hip Pain	□	□	Hepatitis	□	□	**Shortness of breath**
□	□	Upper Leg Pain	□	□	**Gall Bladder Disorder**	□	□	**Palpitations**
□	□	Knee Pain	□	□	Liver	□	□	**Heart arrhythmia**
□	□	Ankle/Foot Pain	□	□	**General Fatigue**	□	□	**Anxiety**
□	□	Jaw Pain	□	□	Muscular Incoordination	□	□	**Sexual dysfunction**
□	□	Joint Pain/Stiffness	□	□	Visual Disturbances	□	□	**Itching**
□	□	Arthritis	□	□	**Dizziness**	□	□	**Psoriasis**
□	□	Rheum. Arthritis	□	□	**Diabetes**	□	□	**Hyperthyroid**
□	□	Cancer	□	□	**Excessive Thirst**	□	□	**Hypothyroid**
□	□	Tumor	□	□	**Frequent Urination**			
□	□	Asthma	□	□	Smoking/Tobacco Use	**For Males Only**		
□	□	**Chronic Sinusitis**	□	□	Drug/Alcohol Dependence	□	□	**Prostate**
□	□	**Other Breathing Abnormalities**	□	□	Allergies	□	□	**Low – T**
			□	□	**Depression**	□	□	**ED**
□	□	**Dermatitis**	□	□	Systemic Lupus			
□	□	**Rash**	□	□	Epilepsy	**For Females Only**		
□	□	Eczema	□	□	HIV/AIDS	□	□	Birth Control Pills
□	□	**High Blood Pressure**	□	□	**Anemia**	□	□	**Hot flashes**
□	□	**Heart Attack**	□	□	**Vitamin D Deficiency**	□	□	**Polycystic ovarian disease**
□	□	**Chest Pains**	□	□	**Metabolic syndrome pre-diabetic**	□	□	**Infertility**
□	□	**Stroke**	□	□	**Bariatric surgery**	□	□	**Painful periods**
□	□	**Angina**	□	□	**Sleep Disturbances**	□	□	**Hormonal Replacement**
□	□	Kidney Stones	□	□	**Mood changes**	□	□	Pregnancy

Other:_____

Front Desk Initials: _____

23. List all prescription medications you are currently taking:

_____
_____
_____

24. List all of the over-the-counter medications you are currently taking:

_____
_____
_____

25. List all Allergies (medications, food, seasonal, etc.) you may have:

_____
_____
_____

26. List all surgical procedures you have had:

_____
_____
_____

27. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

28. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

29. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

30. What activities do you do outside of work? _____

31. What concerns you the most about your problem; what does it prevent you from doing?

_____

32. Have you ever been hospitalized? □ Yes □ No
If Yes, why? _____

33. Indicate if you have any immediate family members with any of the following (Please indicate the relationship to you):
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer (see add. Forms) □ ALS
□ Other: _____

34. Have you had any past injuries or trauma, such as car accidents (ever?), falls, sports injuries, etc.?
□ Yes □ No If "Yes", please provide details:

_____
_____

35. Is there anything else you wish to let us know about you visit today? □ Yes □ No
If "Yes", please provide details: _____
_____

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

Front Desk Initials: _____