

Date \_\_\_\_\_  
Social Security No. \_\_\_\_\_  
Driver's License # \_\_\_\_\_

**CONFIDENTIAL PATIENT INFORMATION**

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip Code \_\_\_\_\_  
E-Mail address \_\_\_\_\_  
Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital Status: M S D W  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_ Work Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Agent's Name \_\_\_\_\_  
Policy # \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Spouse's Occupation \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_ Spouse's Work Phone \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

Referred by \_\_\_\_\_

Have you ever suffered from:	<b>YES</b>	<b>NO</b>	<b>YES</b>	<b>NO</b>
1) Dizziness			8) Cancer	
2) Headaches			9) Asthma	
3) Neck Pain			10) Digestive Disorders	
4) Backaches			11) Nervousness	
5) Arthritis			12) Numbness	
6) Heart Trouble			Explain _____	
7) Diabetes			_____	

Date of Last Physical Examination \_\_\_\_\_  
Purpose of this appointment \_\_\_\_\_  
Other Doctors seen for the condition \_\_\_\_\_  
Has a physician treated you for any health condition in the last year? **YES** **NO**  
Describe \_\_\_\_\_  
Please list any medications you are currently taking: \_\_\_\_\_  
\_\_\_\_\_

**PAYMENT IS EXPECTED AT TIME OF VISIT!**

Name of person responsible for payment \_\_\_\_\_  
Are you insured? **YES** **NO** Insurance Company \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Highlands Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Highlands Chiropractic 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.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
Guardian Signature (if needed) \_\_\_\_\_ Date \_\_\_\_\_

**Is this related to:**  
Auto Accident Yes \_\_\_ No \_\_\_  
Work Injury Yes \_\_\_ No \_\_\_

**If so please turn over and complete!!!**

# Highlands Chiropractic

## IF YOURS IS AN ACCIDENTAL INJURY PLEASE COMPLETE THE FOLLOWING QUESTIONS

◆Date of Accident \_\_\_\_\_ Time \_\_\_\_\_ Location \_\_\_\_\_

◆How did accident occur? Auto Collision On-the-Job Injury Other \_\_\_\_\_

◆Please describe the accident \_\_\_\_\_

◆Did you report the injury to your foreman or employer? YES NO

◆If yes, did he/she recommend care at our office? YES NO

◆If **auto accident**, were you: Driver Passenger Pedestrian

◆Were you struck from: Front Behind  
Driver's Side Passenger Side

◆Condition of Roads: Dry Wet

◆Did your car strike the other(s) involved? YES NO

◆Did the other car strike yours? YES NO

◆If airbag, did it employ? YES NO

◆Position of head: Turned left Turned right Facing forward

◆Position of hands: Left hand \_\_\_\_\_ Right hand \_\_\_\_\_

◆Position of feet: Left foot \_\_\_\_\_ Right foot \_\_\_\_\_

◆List the extent of your injuries as you know them \_\_\_\_\_

◆Did you require post-accident hospitalization? YES NO

◆Check symptoms you have noticed since accident:

Headache	Dizziness	Light Bother Eyes	Diarrhea
Neck Pain	Head Seems Heavy	Loss of Memory	Cold Feet
Stiff Neck	Pins/Needles in Arms	ringing in Ears	Cold Hands
Sleeping Problems	Pins/Needles in Legs	Face Flushed	Stomach Upset
Back Pain	Numbness in Fingers	Buzzing in Ears	Constipation
Nervousness	Numbness in Toes	Loss of Balance	Cold Sweats
Tension	Shortness of Breath	Fainting	Fever
Irritability	Fatigue	Loss of Smell	_____
Chest Pain	Depression	Loss of Taste	_____

◆Have you lost any days of work due to the accident? YES NO Dates: \_\_\_\_\_

◆Insurance Companies involved:  
My company \_\_\_\_\_

Company of person responsible for injuries \_\_\_\_\_

◆Have you been contacted by an insurance adjuster or company representative regarding this claim? YES NO

◆Do you have an attorney that has advised you in this case? YES NO

Signature \_\_\_\_\_

Date \_\_\_\_\_

Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_