

## **New Patient Enrollment Forms**

Greetings,

At Optimum Health Chiropractic we take pride in the care for our patients. At every corner you will notice that we tailor to your needs and comfort. One of those ways is by making these forms available to you online. By making this packet available, we hope that this will reduce the wait time when visiting our clinic. Below you will find brief instructions on filing out this packet.

- 1. Please fill out paperwork completely.**
- 2. On the picture of the body, please put an “X” for pain and an “O” for numbness in the areas you are having trouble with.**
- 3. List each complaint separately and as detailed as possible.**

Thank you very much for taking the time to fill these forms out before your first appointment and we also thank you for thinking of us when you are in need. We look forward to providing the absolute best care possible and exceeding your expectations!

Optimum Health Chiropractic Staff

# OPTIMUM HEALTH CHIROPRACTIC

## Automobile Accident Description

Name: \_\_\_\_\_

Please answer All the questions below.

Acct #: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>1. Your vehicle type</b> <input type="checkbox"/> Car <input type="checkbox"/> Large Truck <input type="checkbox"/> Van <input type="checkbox"/> Pickup Truck <input type="checkbox"/> SUV <input type="checkbox"/> Bus Other _____	<b>2. Your position in vehicle</b> <input type="checkbox"/> Driver <input type="checkbox"/> Front Passenger <input type="checkbox"/> Left Rear Passenger <input type="checkbox"/> Right Rear Passenger Other _____	<b>3. What was your vehicle doing at the time of the accident?</b> <input type="checkbox"/> Stopped at intersection <input type="checkbox"/> Stopped in traffic <input type="checkbox"/> Stopped at light <input type="checkbox"/> Making a right turn <input type="checkbox"/> Making a left turn <input type="checkbox"/> Parking <input type="checkbox"/> Proceeding along <input type="checkbox"/> Slowing down <input type="checkbox"/> Accelerating Other _____
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<b>4. Time/Speed/Damage</b> Date of accident ____/____/____ Time of accident _____ Your vehicle's speed: _____ mph Their vehicle's speed: _____ mph Damage to your vehicle: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Totaled	<b>5. Details of Accident</b> Visibility at time of accident <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good  Who hit who/what? <input type="checkbox"/> You hit other vehicle <input type="checkbox"/> Other vehicle hit you <input type="checkbox"/> You hit...(object) _____	<b>6. Road Conditions</b> Road conditions at time of accident <input type="checkbox"/> Icy <input type="checkbox"/> Wet <input type="checkbox"/> Sandy <input type="checkbox"/> Dark <input type="checkbox"/> Clean and Dry  Point of impact (on your vehicle) <input type="checkbox"/> Head-on <input type="checkbox"/> Left Front <input type="checkbox"/> Right Front <input type="checkbox"/> Rear-end <input type="checkbox"/> Left Rear <input type="checkbox"/> Right Rear
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<b>7. Body Position, etc.</b>  Did you see the accident coming?      Yes <input type="checkbox"/> No <input type="checkbox"/> Were you braced for the impact?      Yes <input type="checkbox"/> No <input type="checkbox"/> Did you have a seat belt on?      Yes <input type="checkbox"/> No <input type="checkbox"/> Did you have a shoulder harness on?      Yes <input type="checkbox"/> No <input type="checkbox"/>	Does your vehicle have headrests? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the position of your headrest at the time of the impact? <input type="checkbox"/> Even with top of head <input type="checkbox"/> Even with bottom of head <input type="checkbox"/> Middle of neck What was the direction of your head at the time of the impact? <input type="checkbox"/> Facing straight forward <input type="checkbox"/> Turned to the right <input type="checkbox"/> Turned to the left
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**8. Additional accident information**  
 Enter any additional information you feel the doctor needs to know, that is not covered by the above check offs.

<b>9. During the accident:</b> Did your body strike the inside of your vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____ Did you lose consciousness during the injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for how long? _____ Your vehicle's estimated damage: _____ Damage to their vehicle: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Totaled Did police show up at the scene? <input type="checkbox"/> Yes <input type="checkbox"/> No Was an accident report filled out? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>10. After the accident:</b> Check off your symptoms right after and a few days following <input type="checkbox"/> Headache <input type="checkbox"/> Rib Pain <input type="checkbox"/> Nausea <input type="checkbox"/> Insomnia <input type="checkbox"/> Neck Pain <input type="checkbox"/> Arm Pain <input type="checkbox"/> Irritability <input type="checkbox"/> Depression <input type="checkbox"/> Neck Stiffness <input type="checkbox"/> Leg Pain <input type="checkbox"/> Fatigue <input type="checkbox"/> Fainting <input type="checkbox"/> Mid back pain <input type="checkbox"/> Dizziness <input type="checkbox"/> Confusion <input type="checkbox"/> Constipation <input type="checkbox"/> Low back pain <input type="checkbox"/> Ears ringing <input type="checkbox"/> Nervousness <input type="checkbox"/> Bladder/Bowel <input type="checkbox"/> Arm Numbness L <input type="checkbox"/> R <input type="checkbox"/> <input type="checkbox"/> Leg Numbness L <input type="checkbox"/> R <input type="checkbox"/> Others: _____ _____
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<b>11. Emergency Room</b> Where did you go after the accident? <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Hospital ER <input type="checkbox"/> Private Doctor How did you get there? <input type="checkbox"/> Drove self <input type="checkbox"/> Somebody else <input type="checkbox"/> Ambulance <input type="checkbox"/> Police Were x-rays done? <input type="checkbox"/> Yes <input type="checkbox"/> No      Was lab work done? <input type="checkbox"/> Yes <input type="checkbox"/> No Body parts x-rayed? _____ What lab work? _____ The x-rays revealed: _____ Treatments: <input type="checkbox"/> Cervical collar <input type="checkbox"/> Ice   Other: _____ Medications: _____ Follow-up instructions: _____ _____	<b>12. Treatment History:</b> Fill in any other doctor(s) seen prior to your first visit to this office. 1. Dr. _____ First visit date: ____/____/____ Specialty: _____ X-rays done? <input type="checkbox"/> Yes <input type="checkbox"/> No Types of treatments received: _____ How many treatments received? _____ Still treating? <input type="checkbox"/> Yes <input type="checkbox"/> No Did treatments benefit you? <input type="checkbox"/> Yes <input type="checkbox"/> No Last visit date: ____/____/____ 2. Dr. _____ First visit date: ____/____/____ Types of treatments received: _____ How many treatments received? _____ Still treating? <input type="checkbox"/> Yes <input type="checkbox"/> No Did treatments benefit you? <input type="checkbox"/> Yes <input type="checkbox"/> No Last visit date: ____/____/____
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Patient Name \_\_\_\_\_

Case # \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

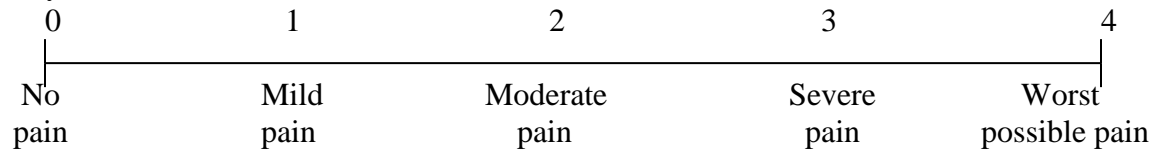
### Functional Rating Index

For Use with **Neck and/or Back Problems** only

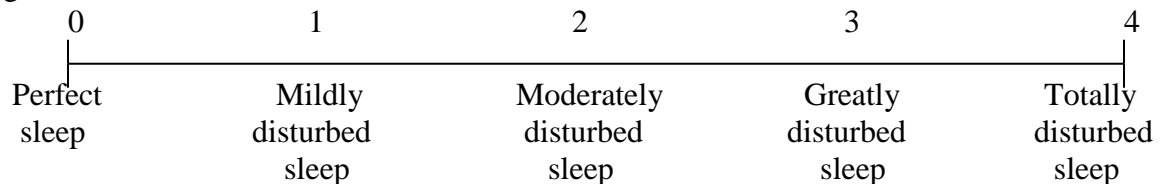
In order to properly assess your condition, we must understand how much your **Neck and/or Back problems** have affected your ability to manage everyday activities.

For each item below, **please circle the number that most closely describes your condition right now.**

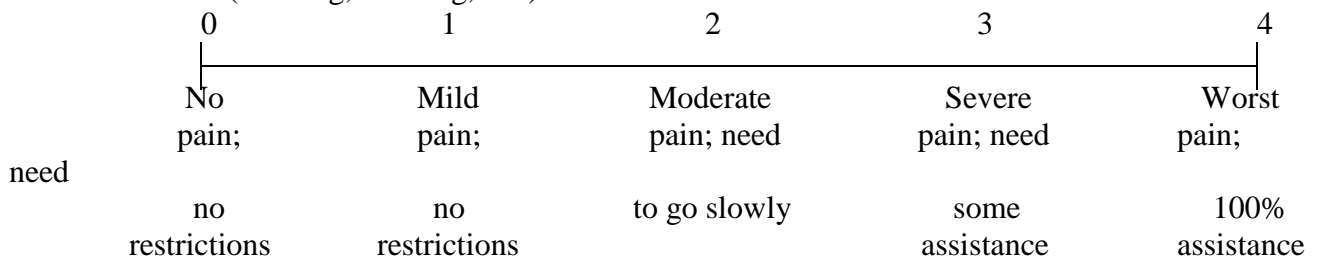
1. Pain Intensity



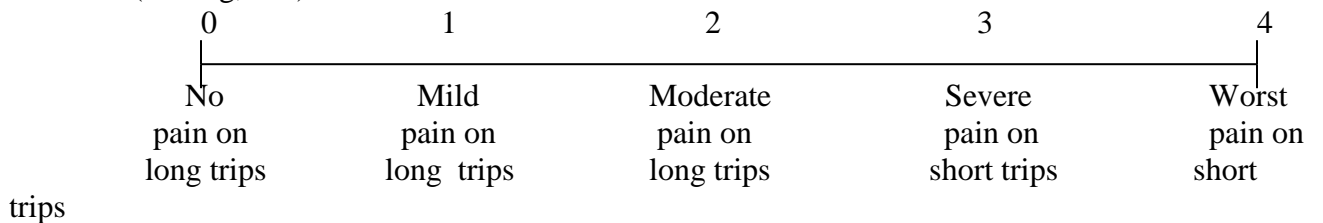
2. Sleeping



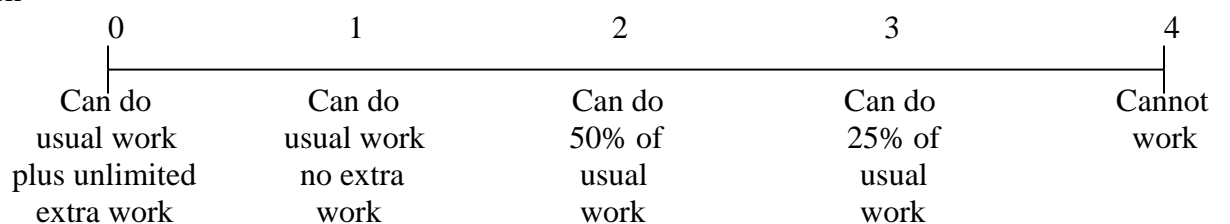
3. Personal Care (washing, dressing, etc.)



4. Travel (driving, etc.)



5. Work



6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

\_\_\_\_\_  
Patient's Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date