Dr. Dianne Elizabeth Starkey, Dr. Patrick Starkey, Dr. Anthony Berardino, Dr. Kellee Leonard
237 Leatherman Rd Wadsworth Ohio
Phone: (330) 336-2120 ~ Fax: (330) 334-8305 Date: ___________

Confidential Patient Information

Patient's Name: ______________________________ Work Status: Part Time Full Time Not employed

Address: ______________________________ Occupation: ______________________________

City/State: ____________________ Zip: ________ Employer: ______________________________

Home Phone: __________ Cell Phone: ___________ Are you limited in work capacity? ________________

Text Reminders: Y___ N___ Cell Carrier: ___________ Driver's License Number: ____________________

Email Address: ______________________________ Chief Complaint: ___________________________

Birth Date: ___________ Age: _____ Sex: M F Relationship of Insured: Self Spouse Child Other

Marital Status: Married Single Widowed Divorced

SS#: ______________________________

Referred by: Family Friend Doctor Internet Event Phone Book ______________________________

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) Yes ____ No ____

Ins. Company: ___________________________ Ins. Phone #: ______________________________

ID#: ______________________________ Group #: ______________________________

Name and Address of Insured (if different): ______________________________

Policy Holder DOB: _________________________ Policy Holders Employer: ____________________

Secondary Insurance Company: ______________________________ #: ____________________

CHECK HERE IF NO CHANGE ☐

Family Physician: ______________________ (Note: May we send your health information to this provider (Y / N)

Person to contact in case of emergency (Name and Phone): ______________________________

What is your goal in our office? ______________________________

I have read and understand THE NOTICE OF PRIVACY PRACTICES, PATIENT RIGHT AND RESPONSIBILITES POLICY, PATIENT RESPONSIBILITIES AND GRIEVANCE POLICY AND PROCEDURES FOR PATIENT. I understand the necessity of these policies and all my questions have been answered in regard to these policies. By signing this form, you give Starkey Chiropractic & Wellness, LLC and staff permission to contact you by either phone, mail, or email.

Signature ______________________________ **Date:** ____________________

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to Starkey Chiropractic & Wellness, LLC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

______________________________ ____________________

Signature of Insured / Guardian **Date**

Dr. Dianne Elizabeth Starkey, Dr. Patrick Starkey, Dr. Anthony Berardino, Dr. Kellee Leonard
237 Leatherman Rd Wadsworth Ohio
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Chiropractic Health Questionnaire

Patient Name:____ **Date:**______________________________

Do you take O Muscle relaxers O Pain Killers O Insulin O Birth Control O Over the counter meds

O Name and dosages of medications or supplements____

____

____

Allergies:____

Accidents or injuries: (Include Date) ____

Surgeries or Hospitalizations: (Include Date) ____

Have you been diagnosed with COVID-19? __________________ If so when? ________________________________

Date of last: Physical Exam ____________________ Spinal X-ray ______________ Blood test ________________

Spinal exam ____________________ Chest X-ray _______________ Urine test ________________

Dental x-ray ____________________ MRI, CT, bone scan ________________________________

Sleep_______ hrs./night Do you sleep on your O Back O Side O Stomach Hours of exercise_____ hrs./wk

Do you smoke: O Yes _______ years O No ______ O Quit ________ years

Do you drink: O No O Yes, daily____, weekly____, monthly____, occasionally_____

Age of mattress ___________ Is your bed comfortable? O Yes O No

What kind of pillow do you use? O Thick O Medium O Thin O None O Memory

Do you wear O Heel lifts O Shoe Lifts O Arch support O Orthotics, describe:

Stress level (circle): No stress -1 2 3 4 5 6 7 8 9 10- Extremely Stressed

Conditions: Please check any that apply to you:

- ○ AIDS
- ○ Alcoholism
- ○ Anemia
- ○ Anorexia
- ○ Appendicitis
- ○ Arthritis
- ○ Asthma
- ○ Bleeding Disorders
- ○ Breast Lump
- ○ Bronchitis
- ○ Bulimia
- ○ Cancer
- ○ Cataracts
- ○ Chemical Dependency
- ○ Chicken Pox
- ○ Diabetes
- ○ Emphysema
- ○ Epilepsy
- ○ Fibromyalgia
- ○ Fractures
- ○ Glaucoma
- ○ Goiter
- ○ Gonorrhea
- ○ Gout
- ○ Heart Disease
- ○ Hepatitis
- ○ Herpes
- ○ High cholesterol
- ○ HIV positive
- ○ Kidney disease
- ○ Liver disease
- ○ Measles
- ○ Migraine headaches
- ○ Miscarriage
- ○ Mononucleosis
- ○ Multiple Sclerosis
- ○ Mumps
- ○ Osteoporosis
- ○ Pacemaker
- ○ Pneumonia
- ○ Polio
- ○ Prostate problem
- ○ Prosthesis
- ○ Psychiatric care
- ○ Rheumatoid arthritis
- ○ Rheumatic fever
- ○ Scarlet fever
- ○ Stroke
- ○ Suicide attempt
- ○ Thyroid problems
- ○ Tonsillitis
- ○ Tuberculosis
- ○ Tumors, growths
- ○ Typhoid fever
- ○ Ulcers
- ○ Vaginal Infections
- ○ Venereal disease
- ○ Whooping cough
- ○ Other:_________

____
____
____
____

Does/Did any of your family members have the above conditions? Which conditions?

____

____

General Symptoms: Check any symptom you currently have or had in the past.

General
- ◯ Bruise easily
- o Chills
- o Dental Problems
- o Depression
- o Difficulty sleeping
- o Dizziness
- o Fainting
- o Fever
- o Forgetfulness
- o Headache
- o Loss of sleep
- o Loss of weight
- o Nervousness
- o Numbness
- o Sweats Day/Night
- o Tiredness
- o Weight gain

Genito-Urinary
- o Blood in urine
- o Frequent Urination
- o Lack of bladder control
- o Painful Urination
- o Sensation loss around buttock/perineum/groin

Gastro-intestinal
- o Poor appetite
- o Bloating
- o Bowel changes
- o Constipation
- o Diarrhea
- o Excessive hunger
- o Excessive thirst
- o Gas
- o Hemorrhoids
- o Indigestion
- o Nausea
- o Rectal bleeding
- o Stomach pain
- o Vomiting
- o Vomiting blood

Cardiovascular
- o Chest pain
- o High blood pressure
- o Irregular heart beat
- o Low blood pressure
- o Poor circulation
- o Rapid heart beat
- o Swelling of ankles
- o Varicose veins

Eye, ears, nose throat
- o Bleeding gums
- o Blurred vision
- o Crossed eyes
- o Difficulty swallowing
- o Double vision
- o Earache
- o Ear discharge
- o Hay fever
- o Hoarseness
- o Loss of hearing
- o Nosebleeds
- o Persistent cough
- o Ringing in ears
- o Sinus problems
- o Vision-flashes
- o Vision-halos

Skin
- o Bruise easily
- o Hives
- o Itching
- o Change in moles
- o Rash
- o Scars
- o Sores that won't heal

Men Only
- o Breast lump
- o Erection difficulties
- o Lump in testicles
- o Penile discharge
- o Sore on penis
- o Other____________

Women only
- o Abnormal pap smear
- o Bleeding between periods
- o Breast lump
- o Extreme menstrual pain
- o Hot flashes
- o Nipple discharge
- o Painful intercourse
- o Vaginal discharge
- o Other ____________

Date of last menstrual period________________

Date of last pap smear________________

Have you had a mammogram, when?________________

Are you pregnant?______mths

Number of children_____

Neck, Back and Extremities Check symptoms you are currently having or have had in the past year.

Neck
- o Pain in neck
- o Neck Stiffness
- o Pinched nerve
- o Neck feels out of place
- o Muscles spasms in neck
- o Grinding/popping sounds in neck

Shoulders
- O Pain in Shoulder joint O Right O Left
- o Pain across Shoulders
- o Can't raise arm O Right O Left
- o Tension in shoulders
- o Pinched nerve in shoulder O Right O Left

Mid-back
- o Mid-back pain
- o Mid- back stiffness
- o Pain between shoulder blades
- o Pain from front to back
- o Muscle spasms in mid-back

Arms and hands
- o Pain in upper arm O Right O Left
- o Pain in elbow O Right O Left
- o Pain in forearm O Right O Left
- o Pain in hand O Right O Left
- o Pain in fingers
- o Pins and needles in arm O Right O Left
- o Pins and needles in fingers O Right O Left
- o Weakness in arms O Right O Left
- o Weakness in hands O Right O Left
- o Hands are cold O Right O Left

Low back
- o Low back pain
- o Low back stiffness
- o Low back weakness
- o Pinched nerve in back
- o Low back feels out of place
- o Muscle spasms in back
- O Sciatic pain

Hips, legs and feet
- o Pain in buttocks O Right O Left
- o Pain in hip joint O Right O Left
- o Pain down leg O Right O Left
- o Pain in knee O Right O Left
- o Pain in ankle O Right O Left
- o Pain in foot O Right O Left
- o Weakness in leg O Right O Left
- o Weakness in knees O Right O Left
- o Leg cramps O Right O Left
- o Pins and needles O Right O Left
- o Other Symptoms______________________

____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of her staff responsible for any errors or omission that I may have made in the completion of this form.

Patient Signature ______________________________ **Date** ______________________

Reviewed by Doctor ______________________________ **Date** ______________________

Dr. Dianne Elizabeth Starkey, Dr. Patrick Starkey, Dr. Anthony Berardino, Dr. Kellee Leonard
237 Leatherman Rd Wadsworth Ohio
Phone: (330) 336-2120 ~ Fax: (330) 334-8305

Patient Name: ______________________________ **Date:** ______________________

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

- spinal manipulative therapy
- palpation
- vital signs
- range of motion testing
- orthopedic testing
- basic neurological testing
- muscle strength testing
- postural analysis
- EMS
- ultrasound
- hot/cold therapy
- radiographic studies
- Other (please explain): ____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke, however, this is a rare occurrence. Some patients will feel some stiffness and soreness following the first few days of treatments. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include → 1: Self-administered, over-the-counter analgesics and rest 2: Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers 3: Hospitalization 4: Surgery
If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO EVALUATE AND TREAT A MINOR: I, __________________ being the parent or legal guardian of __________________________, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Women Only:

To the best of my knowledge I **am / am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation.
(Circle one above) *(Circle one above)*

Missed Appointments:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.
Any appointment that is not canceled 24 hours prior to scheduled appointment will be charged $35 - $70.
The fee will be based on the type of appointment that was scheduled.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: ____________________

Children: ____________________

Others: ____________________

No one: ____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines, voicemails, emails, text message? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: ____________________

Signature: ____________________ Date: ____________________

Dr. Dianne Elizabeth Starkey, Dr. Patrick Starkey, Dr. Anthony Berardino, Dr. Kellee Leonard
237 Leatherman Rd Wadsworth Ohio
Phone: (330) 336-2120 ~ Fax: (330) 334-8305

PATIENT FINANCIAL POLICY

Our primary responsibility is to help you experience good health and we wish to spend our time and energy toward that end. In the interest of good health care practice, it is best to establish a financial policy to avoid misunderstanding.

1. **All accounts are due and payable at the time of your visit unless you make satisfactory arrangements with the office manager.**
2. **It is our policy that if we are filing a claim with your insurance company, we will expect you to pay any unpaid deductible as well as the copayment/coinsurance required by your insurance company at the time of your visit.**
3. **Even though you may have an insurance claim pending, you will receive a statement each month for the outstanding balance of your account. We cannot accept responsibility for collecting an insurance claim or negotiating a disputed claim.**
4. **Remember, insurance reimbursement is a contract between you and your insurance carrier. If after 45 days your insurance has not been paid, we will turn to you for payment. You are responsible for your bills regardless of what your insurance pays.**
5. **If for any reason you have an unpaid balance at 60 days past due, we will automatically charge you $5.00 per month on your unpaid balance.**
6. **To better serve all of our patients, we request that you inform us at least twenty-four hours in advance if you need to cancel your appointment. If for any reason you fail to do this, we will bill you (not your insurance company) for an office visit.**
7. **There will be a $25.00 charge on all returned checks, per submission.**
8. **We do not wish to cause you any undue hard ship, however, we must be able to continue our service to the community.**

I have read this financial policy and understand that, regardless of any insurance coverage I may have, I am responsible for payment of my account within the usual limits of this credit policy. I agree that in the event costs and/or fees are incurred in connection with the collection of my account, I will pay all such costs and fees, including collection costs, Attorney's fees and all court costs.

______________________	______________________________
DATE	**PARTY RESPONSIBLE FOR ACCOUNT**

Dr. Dianne Elizabeth Starkey, Dr. Patrick Starkey, Dr. Anthony Berardino, Dr. Kellee Leonard

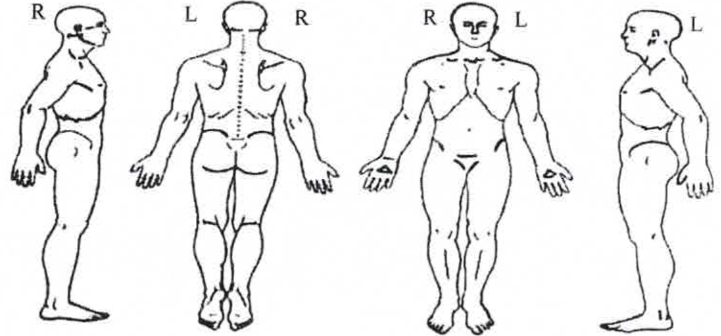
CASE HISTORY

Name: ______________________________ Insurance Change: Yes/No Address change: Yes/No

1. **Describe each Condition / Problem**

	Severity (0=no pain, 10- very severe)	**Frequency** Intermittent	Occasional	Frequently	Constant
A)________________	0 1 2 3 4 5 6 7 8 9 10	0 -25%	26-50%	51-75%	76-100%
B)________________	0 1 2 3 4 5 6 7 8 9 10	0 -25%	26-50%	51-75%	76-100%
C)________________	0 1 2 3 4 5 6 7 8 9 10	0 -25%	26-50%	51-75%	76-100%
D)________________	0 1 2 3 4 5 6 7 8 9 10	0 -25%	26-50%	51-75%	76-100%

(Please mark the figures where you experience pain.)➔



2. Symptoms are worse in the (circle what applies)

-morning -Increase during the day

-afternoon -same all day

-night -decrease during the day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. Symptom (c.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
6. Symptom (d.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
7. Date of Onset: _____/_______ or the time frame of when you last experienced the condition:
   a. __ Acute (within last 3 months) __ Recurrent (multiple episodes <3 months) __ Chronic (continuous > 3 months)
8. How did your symptoms begin? ____________________
9. Have you experienced these before? When?____________________
10. Do your symptoms radiate or cause weakness? ____________________
11. Any changes to bowel or urinary habits? ____________________
12. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
13. Circle the activities that make your problems worse:

    Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping
14. Is there anything you can do to relieve the problems? ____No ____Yes Describe: ____________________

    If No, what have you tried that has not helped? ____________________
15. Have you been treated for this before? ___No ___Yes Who/How long ago? ____________________
16. What treatment did you receive? ____________________
17. Results of previous treatment? ___Good ___Poor Comments ____________________
18. Which activities of daily living does this pain interfere with?____________________
19. List any other major injuries you have had, other than those mentioned above: ____________________

____

20. Have you ever been diagnosed with Covid 19? ________________ If yes, when? ________________

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature ______________________________ Date: __________

STARKEY CHIROPRACTIC & WELLNESS

237 LEATHERMAN ROAD WADSWORTH, OH 44281

PHONE (330) 336-2120

Dear Patient,

Please be advised that it is our office policy that when dealing with personal injury cases, we will bill your automobile insurance for medical treatment related to your automobile accident.

Under your personal automobile insurance you have a portion of your policy called the "Med Pay Policy" which covers your medical bills when you are involved in a car accident. Your auto insurance will then subrogate with the auto insurance company of the person who is responsible for the accident for reimbursement. It is your responsibility to contact your auto insurance to let them know you would like to open a claim for medical payment within 24 hours of being treated in my office. They will then give you a claim number for which you will provide my office with for billing purposes.

I have read and understand Dr. Starkey's , Dr. Berardino's and Dr Leonard's policy regarding personal injury claims and I give them full permission to bill my med pay policy under my automobile insurance for services directly related to the automobile accident I was involved in on ________________________. I further give my insurance company permission to pay Dr. Starkey , Dr. Berardino and Dr. Leonard directly for my medical care.

______________________________________ ______________________

PRINTED NAME **DATE**

____

SIGNATURE

____

WITNESS

STARKEY CHIROPRACTIC & WELLNESS

237 LEATHERMAN ROAD WADSWORTH, OH 44281

PHONE (330) 336-2120

DATE: ____________________

I do herby authorize Dr. Starkey and Dr. Berardino and Dr Leonard to furnish my attorney and/or insurance company with a full report of their examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was involved on _________________,___________.

I herby authorize and direct my attorney and/or insurance company to pay directly to Dr. Starkey , Dr. Berardino and Dr. Leonard such sums as may be due and owing for medical services rendered me both by reason of this accident and by reason of any other bills that are due this office and to withhold upon receipt of any money on her behalf resulting from the following list:

1. A payment by any insurance company for personal injury protection benefits.
2. Medical payment coverage or under any other parts of my policy or any policy to which I may be entitled; a settlement of any claim.
3. A judgement in my favor or otherwise to adequately protect the office of Dr. Starkey and Dr. Berardino.

I herby further give a lien on my case to Dr. Starkey , Dr. Berardino and Dr. Leonard against any and all proceeds whether by PIP, medical payment or settlement, judgment or verdict which may be paid to you, my attorney, any insurance company, or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to Dr. Starkey , Dr. Berardino and Dr Leonard for all medical bills submitted by them for services rendered to me and that this agreement is made solely for said payment. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee. A photocopy of this statement shall be as valid as the original.

DATE ________ PATIENT SIGNATURE: ____

WITNESS: ____

THE FOLLOWING INFORMATION IS REQUIRED PRIOR TO YOU RECEIPT OF A NARRATIVE REPORT AND ITEMIZED BILLING.

Motor Vehicle Accident Report Form

Instructions: Please carefully consider and answer each question as completely as possible

Name_______________________________**Today's Date :**_____________**Date of Accident:**_________

Insurance Companies Involved

Your Insurance Company ____________________________ Ins. Adjustor Name ______________________

Other Vehicle Insurance Company ____

Other Vehicle Ins. Adjustor Name ______________________________

Were you the □ Driver □ Passenger □ Pedestrian

Were you struck from □ Behind □ Right Side □ Left Side □ Front □ Auto was parked

Other, explain:____

Did your car strike the other(s) involved? □ Yes □ No Did the other car strike yours? □ Yes □ No

Were traffic citations issued? □ Yes □ No If "yes", to □ You □ The other driver □ The driver of your car

Did any part of your body strike any part of the car? □ Yes □ No. If "yes", please explain: ______________

____

Did you have a seat belt on? □ Yes □ No Shoulder strap? □ Yes □ No

Does your car have a headrest? □ Yes □ No Height or position? □ Shoulder □ Neck □ Head □ Above

Loss of consciousness? □ Yes □ No If "yes", please explain: ____________________________________

____

Were you stunned? □ Yes □ No How long? ____

Did you feel or hear popping, tearing, or ripping noise in your neck or back? □ Yes □ No

If "yes", please explain: ____

____

Did you feel any pain? □ Yes □ No Where? ____

How long after the accident? ____

Did you find any bruises? □ Yes □ No Where? ____

List the extent of injuries as you know them: ____

____

Instructions: Please check symptoms you have experienced since the accident.

- □ Headaches
- □ Low Back Pain
- □ Face Flushed
- □ Constipation
- □ Skull or Head Pain
- □ Low Back Stiffness
- □ Loss of Color
- □ Excessive Perspiration
- □ Neck Pain
- □ Hip Pain
- □ Dizziness
- □ Loss of Perspiration
- □ Neck Stiffness
- □ Buttock Pain
- □ Fainting
- □ Loss of Taste
- □ Head feels too heavy
- □ Leg Pain
- □ Sinus Trouble
- □ Cold Sweats
- □ Shoulder Pain
- □ Leg Numbness
- □ Loss of Smell
- □ Fever
- □ Shoulder Stiffness
- □ Pins and Needles in Legs
- □ Eye Strain
- □ Pain in Doing Occupation
- □ Arm Pain
- □ Numbness in Feet/Toes
- □ Difficulty Focusing
- □ Swelling. If so, where: _______________
- □ Arm Numbness
- □ Cold Feet
- □ Pain Behind the Eyes
- □ Pins and Needles in Arms
- □ Depression
- □ Eyes Sensitive to Light
- □ Riding in Car
- □ Numbness in Hands/Fingers
- □ Anxiety
- □ Double Vision
- □ Bending
- □ Cold Hands
- □ Tension
- □ Buzzing or Ringing in Ears
- □ Standing
- □ Upper Back Pain
- □ Irritability
- □ Loss of Balance
- □ Sitting
- □ Upper Back Stiffness
- □ Nervousness
- □ Palpitations
- □ Walking
- □ Mid Back Pain
- □ Mental Dullness
- □ Shortness of Breath
- □ Lifting
- □ Mid Back Stiffness
- □ Loss of Memory
- □ Digestive Problems
- □ Twisting and/or Turning
- □ Chest Pain
- □ Difficulty Sleeping
- □ Nausea
- □ Rising to Walk
- □ Rib Pain
- □ Fatigue
- □ Vomiting
- □ Painful Breathing
- □ Tremors
- □ Diarrhea

Did you require post accident care or hospitalization? □ Yes □ No If "yes", where: ____________________

Were you examined? □ Yes □ No If "yes", by whom: ____

Were you X-rayed? □ Yes □ No Was any treatment given? (medication, supports, or recommendations):

____

What is your occupation? ____

Have you missed work as a result of this accident? □ Yes □ No If "yes", how many days? _____________

Description of Accident

Date of Accident: ____________________ Time: _______ □ A.M. □ P.M. Weather ___________________

Road Conditions ____

Streets where accident occurred ____

Your Direction: □ N □ S □ E □ W Other Vehicle Direction: □ N □ S □ E □ W

Your Speed: _______________________ Other Vehicle Speed: _______________________

Your Car Type: ______________________________ Other Car Type: _______________________________

Describe the accident in detail: ____

____

____

____

____

Impact Head Position: □ Up □ Down □ Left □ Right Braking: □ On □ Off

Awareness: □ Very □ Partial □ None

First Aid

Passenger / Passers By / Police / Aid Car / Ambulance / Hospital / Clinic / Home Care

Name:__________________ Location:______________ Assistance:_____________

Comments: ____

Please report any other important information regarding this accident:

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Patient Signature ____ Date ______________________