Advanced Chiropractic Center
Dr. Giuseppe Romano, D.C.

Name: _____ Date of Birth: _____

Date of Accident: _____ Ins. Comp. Name: _____

ID Number: _____ Claim Number: _____

Street Location of Accident: _____

_____

Were you: ☐ Driver ☐ Passenger ☐ Pedestrian

Where in the care where you: ☐ Front – Seat --- ☐Front Right ☐ Front Left

☐ Back – Seat --- ☐Front Right ☐ Center ☐ Front Left

Number of People in your vehicle: _____

Where were you struck from: ☐ Front ☐ Back ☐ Left Side ☐ Right Side

Approximate speed: Yours? _____ Other? _____

Were you knocked unconscious: ☐ Yes ☐ No

Were the police notified: ☐ Yes ☐ No

In your own words, describe accident: _____

_____

_____

_____

Have you been involved in an accident before: ☐ Yes ☐ No

Describe any other accident(s): _____

_____

_____

What are your PRESENT complaints and symptoms: _____

_____

_____

Did you have any physical complaints BEFORE THE ACCIDENT: ☐ Yes ☐ No

If so please describe in detail: _____

_____

_____

_____

Please describe how you felt:

DURING THE ACCIDENT: _____

IMMEDIATELY AFTER THE ACCIDENT: _____

LATER THAT DAY AFTER THE ACCIDENT: _____

THE NEXT DAY AFTER THE ACCIDENT: _____

Where were you taken after this accident: _____

Have you been treated by another doctor since the accident: ☐ Yes ☐ No

If so list the doctors and treatment done:

_____

_____

Since this injury occurred are you symptoms: ☐ Improving ☐ Getting Worse ☐ Same

Check any Symptoms you have noticed since accident:

☐ Headache	☐ Irritability	☐ Numbs Toes	☐ Buzzing in Ears
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Loss of Balance
☐ Stiff Neck	☐ Dizziness	☐ Fatigue	☐ Fainting
☐ Sleeping Problems	☐ Heavy Head	☐ Depression	☐ Loss of Smell
☐ Back Pain	☐ Pins/Needles (Arms)	☐ Eyes Bother by Light	☐ Loss of Taste
☐ Nervousness	☐ Pins/Needles (Legs)	☐ Loss of Memory	☐ Diarrhea
☐ Tension	☐ Numb Fingers	☐ Ring In The Ears	☐ Constipation
☐ Cold Feet	☐ Cold Hands	☐ Upset Stomach	☐ Too Tired or Sluggish
☐ Cold Sweats	☐ Fevers	☐ Face Flushed	

☐ Others: _____

_____

Have you lost time from work as a result of this accident: ☐ Yes ☐ No

If so answer the following:

Last day worked: _____

Type of Employment: _____

Are you being compensated for lost work time: ☐ Yes ☐ No

If so please state type of compensation received: _____

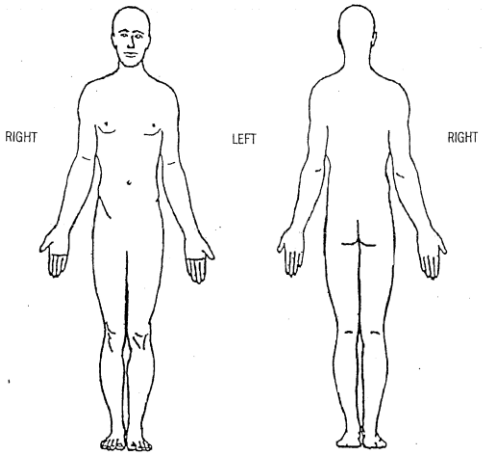
Do you notice any activity restrictions as result of this injury: ☐ Yes ☐ No

If so please describe in detail: _____

_____

_____

/// STABBING XXX BURNING *** TINGLING OOO NUMBNESS +++ ACHING



Pain Level 0 1 2 3 4 5 6 7 8 9 10

NONE MOD SEVERE

1. How would you describe your pain?: ☐ Sharp ☐ Soreness ☐ Throbbing ☐ Tingling ☐ Dull
   ☐ Stiffness ☐ Spasm ☐ Burning ☐ Ache ☐ Weakness ☐ Numbness ☐ Shooting
2. How often is the pain present during your waking day?:

   Pain Level 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
3. Since your problem began, is your pain: ☐ Getting Better ☐ Getting Worse ☐ Staying The Same
4. What makes your problem worst?:
   ☐ Nothing ☐ Walking ☐ Standing ☐ Sitting ☐ Lying Down ☐ Moving ☐ Resting
5. If your problem affecting your ability to work or do other routine daily activities?:

   ☐ No Effect ☐ Affects Work/Activities Greatly ☐ Affects Work/Activities Somewhat

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Advanced Chiropractic Center will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to me and that I am personally responsible for payment. I understand that, if I suspend or terminate my care, any fees for services rendered to me will be immediately due.

Patient Signature: _____ Date: _____