Name: Date:

Healing Hands Chiropractic, LLC

3 Hall Ave, Wallingford CT 06492 (203)626-9994

AUTO INJURY QUESTIONNAIRE

Name_____ Age_____ Birth Date_____/_____/_____
Sex: □ M □ F
Address_____City_____State_____Zip_____
Home#_____ Cell#_____ Work#_____
Email _____ Who referred you to us? _____
Marital Status □ M □ S □ D □ W Number of Children_____ Are you Pregnant? □ Yes □ No
Height_____ Weight_____ Occupation_____ Full Time / Part Time
Employers Name_____ Employers Address_____
Your Auto Ins. Co._____ Policy #_____ Agents Name_____
Do you have Med Pay on Policy? □ Yes □ No □ Unknown Do you have health insurance? □ Yes □ No
NATURE OF ACCIDENT: 1. Date of Accident ___/___/___ 2. In your own words, briefly describe the accident: _____
_____
_____
_____

3. Were you □ Driver □ Front Passenger □ Left rear passenger □ Right rear passenger □ Other_____
4. Who hit who/what? □ You hit other vehicle □ Other vehicle hit you □ You hit object_____
5. Point of impact □ Head-on □ Left Front □ Right Front □ Rear-End □ Left Rear □ Right Rear □ Side
   5a. Damage to your vehicle: none mild moderate severe totaled
6. Your vehicle type □ Car □ Van □ Station Wagon □ Pick-up truck □ SUV □ Other_____
7. What was your vehicle doing at the time of the accident? □ Stopped at an intersection
   □ Stopped in traffic □ Stopped at light □ Making a right turn □ Making a left turn □ Parking
   □ Proceeding along □ Slowing down □ Accelerating (what speed were you going) _____
   □Other_____
8. The other vehicle type □ Car □ Van □ Station Wagon □ Pick-up truck □ SUV
   □ Other_____
9. What was the other vehicle doing at the time of the accident? □ Stopped at an intersection
   □ Stopped in traffic □ Stopped at light □ Making a right turn □ Making a left turn □ Parking
   □ Proceeding along □ Slowing down □ Accelerating(what speed were they going)_____
   □ Other_____
10. Did you have a seat belt on? □ Yes □ No
11. What was the direction of your head at time of impact? □ looking Straight □ Turned Right
    □ Turned Left
12. How many people were in the car with you? □ None □ One □ Two □ Three □ Four □ Other_____
13. Time of Accident_____
    Road conditions at time of accident □ Icy □ Wet □ Sandy □ Dark □ Clean and Dry
14. Visibility at time of Accident □ Poor □ Fair □ Good
15. What was the position of your headrest at the time of impact? □ Up □ Down □ Unknown □ N/A
16. Did your head hit the headrest? □ Yes □ No □ Unknown
17. Did driver side air bags deploy? □ Yes □ No Did passenger side airbags deploy □ Yes □ No
18. What was your hand position on the steering wheel? □ Both hands on □ One hand on □Don't recall

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19. Did you feel any of these symptoms following impact? ___disoriented ___discomfort ___tightness ___frightened ___stunned ___loss of consciousness ___went to hospital
    Immediate pain please list _____
20. Did you have pressure on the brakes? □ Yes □ No □ Do not recall
21. Did you see the accident coming? □ Yes □ No Were you braced for the impact? □ Yes □ No
22. Did your body strike the inside of your vehicle? □ Yes □ No
    *If yes, what part of your body?_____hit what part of the vehicle?_____
23. Did your vehicle hit anything else after the crash? _____
24. Did you lose consciousness during the injury □ Yes □ No *If yes, how long_____
25. Did the police show up at the scene? □ Yes □ No Was a report filed? □ Yes □ No
26. Where did you go after the accident? □ Home □ Work □ Hospital ER □ Private Doctor
27. How did you get there? □ Drove self □ Somebody else □ Ambulance □ Police
    □Other_____
28. Check off your symptoms right after and/or a few days following:

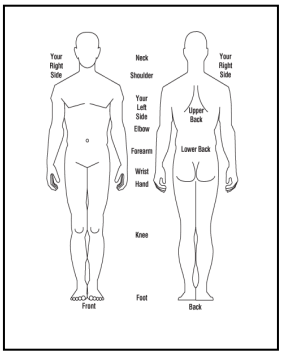
□ Headache	□ Fatigue	□ Hand numbness
□ Dizziness	□ Ringing in ears	□ Neck stiffness
□ Nausea	□ Chest pain	□ Neck pain
□ Diarrhea	□ Shortness of breath	□ Nervousness
□ Anxious	□ Mid-back pain	□ Tension
□ Constipation	□ Cold hands	□ Toe numbness
□ Sleep trouble	□ Fainting	□ Irritability
□ Low back pain	□ Depression	□ Other_____
□ Cold feet	□ Pain behind eyes	
□ Confusion	□ Loss of smell	

29. If you went to the hospital, were x-rays done? □ Yes □ No Was lab work done? □ Yes □ No
    Body parts x-rayed? _____ X-rays revealed? _____
    Lab work revealed? _____
30. Treatments: □ Cervical collar □ Ice □ Medications_____ □ Other_____

Primary Complaint: _____

Symptoms appeared: □ Gradually □ Suddenly Is this pain due to accident? yes/no
How long have you had this pain? _____ Years / Months / Weeks / Days
Is it getting: better worse same

Mark an X on the picture to the right where you are having pain or discomfort --->
Type of pain: □Aching □Burning □Diffused □ Dull □Numbness □Sharp □Shooting □Throbbing □Tightness □Tingling
How frequently do you have this pain? □Constant □Frequent □Intermittent □Occasional
Symptoms are aggravated by: _____
Symptoms are reduced by: _____
Rate the severity of your pain (Circle one): 1 2 3 4 5 6 7 8 9 10 at worst/at best
What time of day is the pain most noticeable? _____
Does it keep you from sleeping? Y/N



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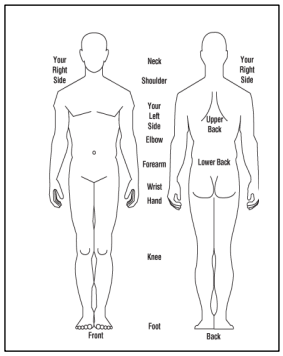
Secondary Complaint:_____

Symptoms appeared: □ Gradually □ Suddenly Is this pain due to accident? yes/no
How long have you had this pain? _____ Years / Months / Weeks / Days
Is it getting: better worse same

Mark an X on the picture to the right where you are having pain or discomfort --->
Type of pain: □Aching □Burning □Diffused □ Dull □Numbness □Sharp □Shooting □Throbbing □Tightness □Tingling

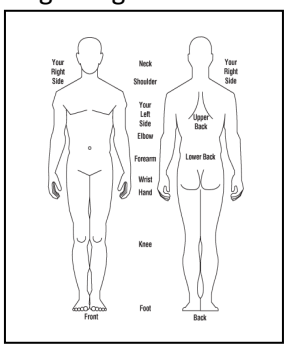


How frequently do you have this pain? □Constant □Frequent □Intermittent □Occasional
Symptoms are aggravated by: _____
Symptoms are reduced by: _____
Rate the severity of your pain (Circle one): 1 2 3 4 5 6 7 8 9 10 at worst/at best
What time of day is the pain most noticeable? _____
Does it keep you from sleeping? Y/N

Third Complaint_____

Symptoms appeared: □ Gradually □ Suddenly Is this pain due to accident? yes/no
How long have you had this pain? _____ Years / Months / Weeks / Days
Is it getting: better worse same

Mark an X on the picture to the right where you are having pain or discomfort --->
Type of pain: □Aching □Burning □Diffused □ Dull □Numbness □Sharp □Shooting □Throbbing □Tightness □Tingling



How frequently do you have this pain? □Constant □Frequent □Intermittent □Occasional
Symptoms are aggravated by: _____
Symptoms are reduced by: _____
Rate the severity of your pain (Circle one): 1 2 3 4 5 6 7 8 9 10 at worst/at best
What time of day is the pain most noticeable? _____
Does it keep you from sleeping? Y/N

Additional Complaint: _____

PLEASE LIST ALL SURGERIES YOU HAVE HAD

Type_____ When_____ Doctor_____
Type_____ When_____ Doctor_____
Type_____ When_____ Doctor_____

HAVE YOU SEEN ANY OTHER DOCTORS FOR THIS CONDITION? _____

Physicians or health care practitioners seen:

Name_____ 2) Name_____
Phone #_____ Phone #_____
Dates of care_____ Dates of care_____
Tests/Treatments_____ Tests/Treatments_____
Results _____ Results_____

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PLEASE LIST ANY PREVIOUS ACCIDENTS/FALLS

What_____ When_____

What_____ _____When_____

Remarks_____

PLEASE LIST ANY MEDICATIONS AND/OR VITAMINS YOU TAKE

What_____Frequency_____Doctor_____

What_____Frequency_____Doctor_____

What_____Frequency_____Doctor_____

Prior Similar Symptoms: Has your history contributed to your current symptoms

□I have NOT had prior symptoms similar to my current complaints

□My history HAS contributed to my current symptoms

□My current complaints DID exist before, but have not been bothering me

□ My history HAS NOT contributed to my current symptoms

□My current complaints ALREADY existed and were worsened

□ I'm NOT SURE if my history has contributed to my current symptoms.

My most recent prior similar symptoms (if applicable) occurred…

□Months ago / □Years ago or on date: ___/___/___

Write in any prior symptom history, not covered above:

_____

Please check all conditions below that you currently have or have had in the past

□AIDS/HIV
□Chicken Pox
□Heartburn/Acid reflux
□Menstrual Irregularities
□Prostate Problems
□Alcoholism
□Chemical Dependency
□Heart Disease
□Migraine Headaches
□Prosthesis
□Allergies
□Constipation
□Heart Palpitations
□Miscarriage
□Rheumatoid Arthritis
□Allergy Shots
□Depression
□Hepatitis
□Mononucleosis
□Ringing in the Ears

□Anemia □Diabetes □Hernia
□Multiple Sclerosis □Sinusitis
□Appendicitis
□Diarrhea
□ Herniated Disc
□Mumps
□Sleeping Problems
□Arthritis
□Difficulty Swallowing
□Herpes
□Nervousness/Anxiety
□Thyroid Problems
□Asthma/Short of breath
□Dizziness
□High Blood Pressure
□Osteoporosis
□Tonsillitis
□Bleeding Disorder
□Eating Disorder
□High Cholesterol
□Pacemaker

□Tuberculosis
□Breast Lump
□Emphysema
□IBS
□Parkinson's Disease
□Tumors/Growths
□Bronchitis
□Epilepsy
□Kidney Disease
□Pinched Nerve
□Ulcers
□Cancer
□Glaucoma
□Liver Disease
□Pneumonia
□Upset Stomach
□Cataracts
□Headaches
□Measles
□Polio
□Vaginal Infections

Any other conditions not listed above: _____

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OCCUPATIONAL INFORMATION

Do any of your work activities aggravate your present main complaints? Please describe:_____

_____

Job Involves: □ Sitting □ Standing □ Desk □ Counter □ Other _____ How long? _____

□ Lifting How much weight? _____ □ Bending □ Stooping □ Twisting □ Turning

Type of shoes □ High heels □ Boots □ Arch supports □ Other_____

How long do you speak on the telephone each day? _____ □ Traditional telephone receiver □Headset

Physical activity at work: □ Sedentary □ Light manual labor □ Manual labor □ Heavy manual labor

HOW HAS THIS AFFECTED YOUR LIFE?

Circle one Have you missed work? YES NO If yes, how long?_____

Has the quality of your work been affected? YES NO Are you able to do household chores? YES NO

Has this problem interfered with your social life? YES NO

Has it interfered with spending time with family and friends? YES NO

Has it interfered with your recreational activities? (Exercise, Golf, Tennis, etc.) YES NO

Please List:_____

Please list any other daily activities/duties that are difficult for you due to the pain you're having.

_____

_____

DISABILITY

Do you have a permanent disability rating? _____ Location_____

Date received_____Rating Percentage_____

HEALTH HABITS:

□ Smoking: _____ Packs per Week

□Alcohol: _____Drinks per Week

□ Coffee/Caffeine: _____Drinks per Week

□ Other Chemical Dependencies:_____

□High Stress Level: High/ Moderate/ Low

Reason: _____

Exercise: □None □ Moderate □ Daily

□ Heavy Sleep: Hours per night_____ Type of mattress_____ Naps_____

Do you sleep on your □Back □Side □Stomach

Please describe your sleep (ex. deep/restful, interrupted, etc.) _____

Any special diets?_____

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.

_____ _____

Signature Date

Name: Date:

Terms of Acceptance

When a patient seeks chiropractic health care and when a chiropractor accepts a patient for such care, it is essential that both are speaking and working for the same goals. Chiropractic does NOT diagnose or treat disease. Chiropractic has only one goal: To Locate, Analyze and Correct Spinal Interference to the Nervous System. The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The SUBLUXATION (spinal misalignment producing nerve interference,) in and of itself, is a detriment to life and health. Correction of the subluxation through a specific chiropractic adjustment allows the body to function at its optimum level. This allows the INNATE healing power of the body to work at maximum efficiency to restore, maintain and promote natural health. WE DO NOT DIAGNOSE CONDITION(S) OR DISEASE(S) OTHER THAN VERTEBRAL SUBLUXATIONS. WE DO NOT OFFER TREATMENT OF CONDITION(S) OR DISEASE(S) OTHER THAN VERTEBRAL SUBLUXATIONS. WE PROMISE NO CURE FROM ANY CONDITION(S) OR DISEASE(S). THE CHIROPRACTIC ADJUSTMENT RESTORES LIFE AND HEALTH TO ITS FULLEST POTENTIAL!!!

I, having read the above statement and understanding it fully, do undertake chiropractic health care on this basis.

X_____ _____

Signature Date

HIPAA COMPLIANCE SIGNATURE PAGE

Patient Name_____

Person/s you are ***releasing*** information to:

_____

_____

Please choose one _____ Any information _____ Billing information only

Person/s ***not to release*** information to: _____

Patient signature

OR

Guardian signature_____

Print Name if Guardian_____ Date_____

A copy of complete HIPPA policy is available by request.

____Refused to sign_____ revised 2-12-19

Name: Date:

Treatment Disclaimer

Is your treatment for any of the following? Please circle **YES/NO**

Worker's Comp **Yes** **No**

Personal Injury ** **Yes** **No**

Auto accident ** **Yes** **No**

Auto Accident on Company time **Yes** **No**

Health & Wellness **Yes** **No**

Other ie: slip/fall **Yes** **No** (If **Yes**, please explain)

_____

I understand that if at any time during my care at Healing Hands Chiropractic, LLC it is deemed as Worker's Compensation that HHC does not participate in Workers Comp. If my care is found to be Workers Comp. HHC will provide notes at an additional fee, but will not provide reports, scans etc.

Please note, If this is a **Personal Injury or **Auto** case we require a Letter of Protection, Letter of Representation, and Medical Authorization **PRIOR TO CARE BEING GIVEN.**

_____ Date_____

Patient Signature

Name: Date:

PRE-SCAN Checklist for: _____ Date _____

Your nervous system controls and regulates every cell of your body. We use an instrument that reveals how well your nervous system is working.

Please let us know if we need to be mindful of the following:

Drinking coffee or tea can excite the nervous system.
Have you had any of these caffeinated beverages today?

❑ **No** ❑ **Yes**

About ___ cups.

Cola drinks contain caffeine and chemicals that can affect the nervous system.
How many sodas have you had today: _____ .

Nicotine is a nervous system stimulant.
Have you used any tobacco today?

❑ **No** ❑ **Yes** How much: _____

Common, over-the-counter drugs can impact the nervous system.
Have you taken any of these types of drugs today?

❑ **No** ❑ **Yes** _____

Many prescription drugs and muscle relaxers affect the nervous system.
Have you taken any type of prescription medication today?

❑ **No** ❑ **Yes** _____

Excessive exposure to the sun affects the accuracy of your scan.
Have you had a sunburn in the last five days? ❑ **No** ❑ **Yes**

Bath salts, oils or sunscreen on your skin can influence instrument sensitivity.
Have you used any of these products today? ❑ **No** ❑ **Yes**

Vigorous physical activity can exaggerate your scan results.
Have you had a workout today? ❑ **No** ❑ **Yes**

Stress, depression, anxiety or emotional upsets can affect nervous system tension.
Compared to a typical day, are you currently experiencing an increased level of stress? ❑ **No** ❑ **Yes**