B&M CHIROPRACTIC, Inc.

PERSONAL INJURY INFORMATION

Personal

Name _____ Date of Birth _____ Sex □ M □ F
Address _____ City _____ Zip Code _____
Social Security # _____ Drivers License # _____
Home # _____ Cell # _____ E – Mail _____
Height ____ Weight ____ Age ____ Marital Status: S □ M □ D □ W □ How Many Children? ____
Occupation _____ Employer _____
Employer Address _____ Office Phone # _____
Spouse's Name _____ Birth Date _____
Occupation _____ Employer _____ Office Phone # _____
Primary Care Physician Name _____ PCP Tel # _____
Whom may we thank for referring you? _____

Emergency Contact Information

Name _____ Relationship _____
Phone # _____ Alternate Phone # _____

Nature of Incident

Date of Incident: _____ Time of Day: _____ □ AM □ PM
Were you: □ Driver □ Passenger □ Front seat □ Right rear seat □ Left rear seat □ Pedestrian
Were you wearing a seatbelt at the time of impact? □ Yes □ No
Number of people in your vehicle? _____ Other vehicle? _____
What direction were you headed? □ North □ East □ South □ West
Name of street: _____
What direction was the other vehicle headed? □ North □ East □ South □ West
Name of street _____
Were you struck from: □ Behind □ Front □ Right side □ Left side
Did any part of your body strike anything in the vehicle? □ Yes □ No
If yes, please describe _____
Were you jolted: □ Side to side □ Back & forth □ Throughout your seat □ Other
Was this vehicle equipped with airbags? □ Yes □ No
If yes, did it/they deploy? □ Yes □ No
Did you lose consciousness, faint or black out? □ Yes □ No If yes, for how long? _____

Please describe the incident: _____
_____
_____
_____
_____

Did the police come to the accident scene? □ Yes □ No
Was a police report made? □ Yes □ No

Have you lost any time off work as a result of this incident? □ Yes □ No
If yes: □ Hours □ Days □ Weeks □ Months Day last worked: _____
Are you working now? □ Yes □ No

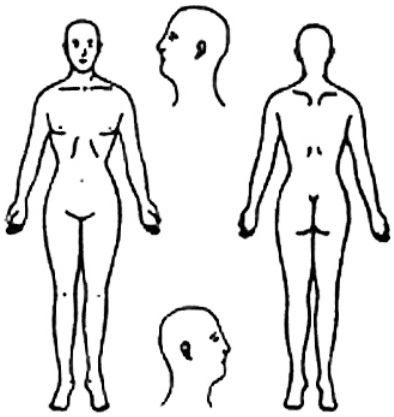
Symptoms / Injuries

Immediately following the incident, did you feel: □ Disoriented □ Shaken up □ Nervous □ Dazed □ Scared □ Confused □ Shocked □ Panicky □ Stunned □ Nauseous □ Dizzy

Was there any emergency care given at the scene of the incident? □ Yes □ No
Were you taken to a hospital? □ Yes □ No Name of hospital: _____
How did you get there? □ Ambulance □ Private Transportation
Were x rays taken? □ Yes □ No
Was medication prescribed? □ Yes □ No
Have you received any special test? □ CT scans □ MRI □ Other: _____

Have you been treated by another doctor since the incident? □ Yes □ No
If yes, name of doctor / address: _____
Type of treatment received: _____

Please mark your areas of pain on the figure below:



Injuries due to this incident began: □ Immediately after □ Hours later □ Following days
Since this injury occurred, are your symptoms: □ Getting worse □ Same □ Improving

Do you notice any activity restrictions as a result of this injury? □ Working □ Walking □ Stooping □ Bending □ Twisting □ Driving □ Lifting □ Carrying □ Dancing □ Sexual activity □ Hobbies □ Standing for long periods □ Sitting for long periods □ Vacuuming □ Caring for children □ Sport activities □ Talking on the phone □ Running □ Climbing stairs/ladders □ Reaching □ Pushing/pulling □ Stretching □ Lying on back □ Lying on stomach □ Lying on side □ Other activities that cause pain: _____
_____

Have you been involved in an accident in the last 5 years? (Auto/Work/Other) □ Yes □ No
If yes, please describe, including date and type of accident(s) as well as injury(ies) received:
_____
_____
_____
Completely resolved? □ Yes □ No Any Residual pain? □ Yes □ No

Do you have any congenital factors or ailments which relate to your present condition?
□ Yes □ No If yes, described: _____

FEMALES: Are you pregnant? □ Yes □ No □ Maybe

Please check (X) all present symptoms

HEAD:
- □ Headaches
- □ Head feels heavy
- □ Tension
- □ Light-headedness
- □ Nausea
- □ Dizziness
- □ Vomiting
- □ Loss of balance
- □ Loss of memory
- □ Light bothers eyes
- □ Blurred vision
- □ Double vision
- □ Loss of hearing
- □ Ringing in ears
- □ Fainting

NECK:
- □ Pain in neck
- □ Neck pain with movement
- □ Neck stiffness
- □ Pinched nerve in neck
- □ Neck feels out of place
- □ Muscle spasms in neck
- □ Grinding sounds in neck
- □ Popping sounds in neck
- □ Arthritis in neck

SHOULDERS:
- □ Pain in shoulder joint (R - L)
- □ Pain across shoulders
- □ Bursitis (R - L)
- □ Arthritis (R - L)
- □ Tension in shoulders
- □ Pinched nerve in shoulders
- □ Muscle spasms in shoulders

ARMS & HANDS:
- □ Pain in upper arm
- □ Pain in elbows
- □ Pain in forearms
- □ Pain in hands/wrists
- □ Pain in fingers
- □ Pain upon movement
- □ Loss of grip strength
- □ Sensation of pins & needles in arms
- □ Sensation of pins & needles in fingers
- □ Numbness in arms (R - L)
- □ Numbness in fingers (R - L)
- □ Fingers go to sleep
- □ Hands cold
- □ Swollen joints in fingers
- □ Arthritis

MID-BACK:
- □ Mid back pain
- □ Pain between shoulder blades
- □ sharp stabbing pain
- □ Dull achy pain
- □ Pain from front to back
- □ Muscle spasms

CHEST:
- □ Chest pain
- □ Shortness of breath
- □ Pain around ribs
- □ Breast pain
- □ Irregular heart beat

ABDOMEN:
- □ Nausea
- □ Nervous stomach
- □ Constipation
- □ Diarrhea
- □ Gas
- □ Hemorrhoids

LOW BACK:
- □ Low back pain
- □ Low back pain is worse when:
  - □ walking
  - □ working
  - □ lifting
  - □ stooping
  - □ standing
  - □ sitting
  - □ bending
  - □ coughing
  - □ lying down
- □ Slipped disc
- □ Pain relieves when_____
- □ Muscle spasms
- □ Low back feels out of place
- □ Pain in kidney area
- □ Arthritis

HIPS, LEGS & FEET:
- □ Pain in buttocks (R - L)
- □ Pain in hip joints
- □ Pain down legs (R - L)
- □ Pain down both legs
- □ Knee pain
- □ Leg cramps
- □ Cramps in feet
- □ Pins & needles in legs (R - L)
- □ Numbness in legs (R - L)
- □ Numbness in feet
- □ Numbness in toes
- □ Feet feel cold
- □ Swollen ankles (R - L)
- □ Swollen feet (R - L)

GENERAL:
- □ Heart disease
- □ Stroke
- □ Pace maker
- □ Tumors
- □ Cancer
- □ Diabetes
- □ Hypoglycemia
- □ High blood pressure
- □ Cholesterol
- □ Thyroid
- □ Arthritis
- □ Hepatitis
- □ Tuberculosis
- □ AIDS
- □ Coffee ____ cups/day
- □ Tea _____ cups/day
- □ Cigarettes __ pks/day
- □ Alcohol
- □ Nervousness
- □ Irritable
- □ Gain of weight
- □ Loss of weight
- □ Fatigue
- □ Depressed
- □ Insomnia
- □ Asthma
- □ Arthritis
- □ Other: _____ _____

WOMEN ONLY:
- □ Menstrual pain
- □ Irregularity
- □ Cramping
- □ Cycle ____ days
- □ Birth control
- □ Menopause
- □ Hysterectomy
- □ Tumors
- □ Are you or do you think you are pregnant

MEN ONLY:
- □ Urinary frequency
- □ Difficulty starting urination
- □ Night urination
- □ Prostate pain/swelling

Insurance Information

Your Auto Insurance Name: _____ Policy #: _____
Claim #: _____ Phone #: _____ Adjustor: _____
Address: _____

Other Driver's Vehicle Insurance Name: _____ Policy #: _____
Claim #: _____ Phone #: _____ Adjustor: _____
Address: _____

Attorney Name: _____ Phone #: _____
Address: _____

Health Insurance: **PLEASE PROVIDE US WITH YOUR INSURANCE CARD**

I certify to the best of my knowledge, the above information is complete and accurate. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that B & M Chiropractic, Inc. 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 B & M Chiropractic, Inc. 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. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of the service and no financial arrangements have been made, you will be responsible for legal, collection and any other expenses incurred in collecting your account.

Signature: _____ Date: _____

□ Adult Patient □ Parent or Guardian