

ABOUT THE PATIENT

Wave Chiropractic, 5233 4th Avenue Circle E, Bradenton, FL 34208

Name _____ Today's Date _____ Birthdate _____ Age _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____ Gender M F
Significant Other's Name _____ Kid's Names and Ages _____
Your Employer _____ Type of Work _____
e-Mail Address _____ Have you been to a chiropractor before? No Yes
Emergency Contact _____ ph# _____
Name of Medical Doctor(s) _____
How did you hear about us? _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Wave Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: Cash Check Credit Card Car/Work Ins.

Patient/Parent Signature Date _____
(This represents a long term authorization for all occasions of service)

PRESENT COMPLAINTS

1. _____
Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____

2. _____
Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____

3. _____
Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____

COLLISION INFORMATION

Where did the collision occur: Street: _____ City: _____ State: _____
Date when collision occurred: _____ AM or PM. Was the road: Dry Wet Snowy Icy
Where you the: Driver Front middle passenger Front right passenger Back left Back middle Back right
Describe what happened: _____

PROVIDERS SEEN

List all providers seen since injury occurred:

1. Clinic/Doctor/Hospital Name _____ City _____

2. Clinic/Doctor/Hospital Name _____ City _____

Yes No Do you have pictures of your vehicle? Where is it being repaired? _____

Yes No Do you have a copy of the police report?

Name of your Attorney if you have one: _____

Name of Your Car Insurance Co. _____ Your Health Ins. Co. _____

CRASH DETAILS

Yes No If driving, were both hands on the wheel at impact?

Yes No If passenger, did your hands brace yourself?

Yes No Did you have your seat belt and shoulder strap on?

Yes No Was your seat up at the time of impact?

Yes No Were you wearing a bulky coat or slippery pants?

Yes No Did the seat belt engage?

Yes No Did the airbag engage?

Yes No Did you hit the dash, steering wheel or window?

Yes No Did you know you were going to be hit?

Yes No Did you brace yourself with hands or feet?

Yes No If driving, was your foot on the brake at impact?

Yes No Was your head turned at impact?

Yes No Were you leaning forward?

Yes No Did your glasses fly-off at impact?

Yes No Was your body turned at the moment of impact?

Yes No Did you get hit into another car, tree, railing, etc?

Yes No Any damage or marks on your vehicle, the vehicle that hit you, or another object that was hit?

What part of the vehicle was hit? _____

1. What make and model of vehicle were you in? _____ The other vehicle? _____

2. What kind of seat were you in? Bucket Bench Fabric Leather/Vinyl

3. Did the car have headrests? Yes No

4. Did you hit your head on the headrest? Yes No On the back window if in a small truck? Yes No

5. Was the headrest positioned: below level with above the center of your head

6. Did your head hurt after the collision? Yes No Did your TMJ/jaw hurt after the collision? Yes No

7. How soon after the collision did you notice any pain? _____

8. Did the crash affect: dizziness memory concentration headaches balance nightmares breathing
 fatigue irritability ability to read ability to listen appetite nausea vision

9. Is there anything else you want us to know? _____

Please mark all areas of concern

