HODGES
CHIROPRACTIC

TO BE FILLED OUT BY PATIENT

Last Name: _____ **First Name:** _____ **MI:**___
D.O.B: _____ **SS#:** _____
Address: _____ **Apt #:** _____
City: _____ **State:** _____ **Zip:** _____
Height: _____ **Weight:** _____
Marital Status: ○ **Single** ○ **Married** ○ **Divorced** ○ **Widowed**
Phone Numbers **H:** _____ **C:** _____ **W:** _____
Email Address: _____
How were you referred to us? _____
Who should we contact in case of an emergency? _____
Attorney Name: _____ **Firm:** _____
Attorney Phone: _____ **Attorney Fax:** _____

AUTO (if you do not know, leave it blank)

Insurance Name: _____ **Policy:** _____
Phone #: _____ **Fax:** _____
Billing Address: _____
City: _____ **State:** _____ **Zip:**_____
Claim #: _____ **D.O.A:** _____
Effective Date: _____ **Valid through:** _____
Adjuster: _____ **Adjuster #:** _____
Deductible: _____ **% Covered:** _____

MEDICAL (if applicable)

Insurance Name: _____ **Phone#:** _____
Billing Address: _____
City: _____ **State:** _____ **Zip:**_____
Insurance ID#: _____ **Group #:** _____
Co-pay: _____ **Deductible:** _____
PCP Required: ○ **Yes** ○ **No**
Participating ○ **Yes** ○ **No**
Type of insurance: ○ **PPO** ○ **POS** ○ **HMO** ○ **Other** _____

MVA INJURY INFORMATION

Name: _____ Age: _____ Sex: ____ Handed: __LT__ RT
Referred By: _____ D.O.I. _____ Today's Date: _____

Is this the result of: O Auto Accident O Slip and Fall O On the Job O Other
Please give a description of accident:
_____
_____
_____
Were you:
○ Driver ○ Passenger ○ Front Seat ○ Back Seat
○Wearing a seatbelt ○Not wearing a seatbelt
○ Struck from Rear ○From Front ○ From Left ○ From Right
○Lost Consciousness if so how long? _____
When did you seek care? ○ Immediately ○ Same Day ○ Next Day ○ Other _____
Where did you seek care? ○ Emergency Room ○ Other _____
What type of treatment did you initially receive? _____
_____
List all physicians that have treated you for this injury: _____
Please list your chief complaint(s) and/or symptom(s):

1) _____
2) _____
3) _____
4) _____
5) _____

Do you have **neck pain**? □ Yes □ No
My pain began? □ Gradually □ Suddenly
My pain is: □ Constant □ Intermittent
My Pain goes into: □ Right Arm □ Right Hand □ Left Arm □ Left Hand
I have numbness/tingling in: □ Right Arm □ Right Hand □ Left Arm □ Left Hand
Pain is worse when I look □ Right □ Left □ Up □ Down
Additional neck pain info: _____

Do you have **back pain**? □ Yes □ No
Location of pain? □ Upper □ Lower □ Middle
My pain began? □ Gradually □ Suddenly
My pain is: □ Constant □ Intermittent
My Pain goes into: □ Left leg □ Left Foot □ Right leg □ Right foot
I have numbness/tingling in □ Left leg □ Left Foot □ Right leg □ Right foot
I have experienced loss of □ Bladder □ Bowel
Additional back pain info: _____

Have you experiencing **headaches**? □ Yes □ No
My pain is? □ Constant □ Intermittent
The pain is? □ Mild □ Moderate □ Severe
Location of Headache? □ Front □ Back □ Left □Right
Tight banging feeling around head? □ Yes □ No
Associated with neck pain? □ Yes □ No
Caused visual trouble? □ Yes □ No
Additional headache info:
_____

Since the injury/accident, have you experienced any of the following symptoms?
□ Blurred Vision □ Double Vision □ Ringing in Ears □ Dizziness
□ Fatigue or Tire Easy□ Anxiety □ Depression □ Pain All Over
□ Morning Stiffness □ Numbness/Tingling □ Noise Sensitivity □ Light Sensitivity
□ Personality Change □ Memory Problems □ Slowed Thoughts □ - Sexual Functions
□ Urinary Urgency □ Irritable Bowels □ Impaired Concentration

Prior to this accident/injury I was diagnosed with the following medical conditions:
□ Asthma □ Migraine Headache □ Back Injury □ Anxiety
□ Depression □ High BP □ Thyroid Issues □ Alcohol Abuse
□ Drug Abuse □ Stomach Problems □ Head Injury □ Neck Injury
□ Broken Bones □ Dislocated Bones □ Heart Problems □ Low BP
□ Diabetes □ Seizures □ Liver Disorder

Do you have any of the following problems?
□ Ulcer □ Black Stools □ Loss of Bladder □ Difficulty Swallowing
□ Ear Pain □ Intestinal Bleeding □ Blood in Stool □ Loss of Bowel Control
□ Pain chewing □ Other: _____

Do you have trouble with performing any of the following functions?
□ Bending □ Climbing □ Reaching □ Twisting □ Lifting □ Squatting
□ Using Hand □ Pushing □ Pulling □ Turn Head □ Kneeling □ Walking
□ Standing □ Lift Arm □ Gripping □ Writing □ Sitting □ Typing
□ Standing □ Reaching Up

Based on a Pain Scale of 1 to 10 (10 being the worst), rate your pain level (circle one)
1 2 3 4 5 6 7 8 9 10

Have you ever been involved in an auto accident in the past? _____ Y ___ N If so, when? Give a description. _____

Your current employment status? □ Full Time □ Part Time □ Unemployed

What type of work do you do on your job? _____
_____

Did you miss any work because of this accident? ____ Y ____ N If so, what days, and why? _____

Were any of your current problems present before this accident or injury? ___ Y ___ N
If so which ones? _____

Have you been diagnosed with any medical problems in the past? If so what? _____
_____

List all surgeries that you have had in the past: _____
_____

Have you ever been admitted to the hospital for longer than 24 hours? If so what?
_____

List all prescription and non-prescription medications that you are currently taking:

_____ _____
_____ _____
_____ _____
_____ _____

Do you? □ Smoke? If yes PPD _____ □ Drink Alcohol, if so how often?
□ Use Illegal Drugs? _____

Check all previous treatments that you have received for pain or accident in the past:
□ Physical Therapy □ Exercise Therapy □ Epidural Injection □ Chiropractic
□ TENS Unit □ Massage Therapy □ Biofeedback □ Trigger Point

For female patients only:
When was your last normal period? ____/____/____
Are you pregnant? □ Yes □ No
Do you take birth control? □ Yes □ No

Printed Name: _____ Date:_____
Signature: _____