



Confidential Patient Health Record

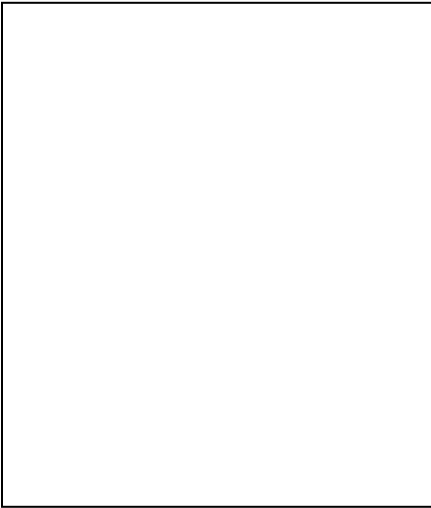
Last Name/First Name/ Middle Initial: _____ Date: _____
 Home Ph#: _____ Cell Ph#: _____ Work Ph#: _____
 Street Address: _____
 City/State/Zip Code: _____
 Date of Birth: _____ Age: _____ Social Security#: _____
 Sex: Male Female Status: Married Single Widowed Divorced/Separated
 Occupation at the Time of Accident: _____
 Employer: _____
 Are You Currently Unemployed Due to Accident? YES NO
 Type of Work: Office/Clerical Light Labor Moderate Labor Heavy Labor
 Driver's License #: _____ State: _____
 In Case of Emergency, Please Contact (Please Include Name, Phone #, and Relationship): _____

GENERAL ACCIDENT HISTORY:

Date of accident: _____ Time: _____ AM / PM
 On what street or intersection did the accident occur? _____ City/State: _____
 Was the accident on the job? YES / NO
 You were: Driver Front Seat Passenger Rear Seat Passenger Motorcycle Passenger
 Motorcycle Operator Other: _____
 Vehicle driven by: _____
 What type of vehicle were you in? (Year & Model) _____
 What type of vehicle impacted yours? (Year & Model of other car) _____
 Your estimated speed at moment of accident: _____ Stopped Slowing Accelerating
 The other vehicles speed at the moment of accident: _____ Stopped Slowing Accelerating
 What type of impact was the auto accident? (Check all that apply) Head-on Collision Front Impact
 Broad-side Collision Rear-end car in front of you Rear impact Non-collision
 Road Conditions: Dry Rainy Wet Snow Clear Dark Icy Other: _____
 Visibility at the time of the accident: Poor Fair Good Other: _____
 Where was the headrest positioned on your head? Up Down Don't know
 Was the seat broken? YES NO
 Did you have your seatbelt on during the accident: Yes No
 Did air bag deploy? YES NO If yes, were you struck? YES NO
 How was your body positioned during the accident? _____
 How was your head positioned during the accident? _____
 Hands: One on wheel Two on wheel N/A _____
 Did you apply your own brakes? YES NO

Accident description: (Be specific) _____

ACCIDENT DIAGRAM:



DURING THE ACCIDENT

Did you know the accident was coming? YES NO

Did you strike any parts of the vehicle? YES NO

If yes, describe: _____

During and after the crash what happened to your vehicle? (Check all that apply)

Kept going straight Spun around Kept going straight hitting a car in front

Hit a stationary object Spun around & hit a stationary object

Was hit by another vehicle Other _____

Did your vehicle hit anything following the accident? YES NO

If yes, describe: _____

Wearing hat or glasses? YES NO

If yes, were they still on after the accident? YES NO _____

Did you lose consciousness? YES NO

If yes, for how long? _____

Did you get any bleeding cuts? YES NO

Did you get any bruises? YES NO

Are you pregnant? YES NO If yes, how far along? _____

Estimated property damage to your vehicle: \$ _____

Estimated damage to other vehicle(s): None Minimal Moderate Major

Were the police on the scene? YES NO

If yes, was a report made? YES NO

AFTER THE ACCIDENT:

Where did you go after the accident? Hospital _____ Urgent Care _____

Home Work Other _____

If you answered Hospital or Urgent Care, please specify day and time: _____

How did you get to the hospital? Ambulance Drove self someone else drove Other: _____

Did you stay in the hospital overnight? Yes No

Did you receive the following in the hospital: Pain medication Muscle relaxer Neck brace

stitches MRI Examination X-rays CAT scan Cast Other _____

Who was the first doctor that treated you?

Name: _____

Date seen: _____

Were you examined? Yes No

Were x-rays taken? Yes No Were you: Sitting laying down Standing

If x-rays were taken, what areas of the body were x-rayed? _____

Did you receive treatment? Yes No

If yes, what kind of treatment did you receive? _____

What benefits did you receive from the treatment? _____

I hereby authorize Dr. Ju to examine me, including X-rays if indicated by my exam, and to release my records to anyone I designate. I further authorize treatments deemed necessary by the findings, and wish all my chiropractic records to be held in strict secret confidence and not to be given to anyone without my written consent. I authorize payment directly to the doctor from my insurance company and I clearly understand they I am totally responsible for payment should my insurance company deny payment, or make payment directly to me.

BY SIGNING YOUR NAME BELOW, YOU CERTIFY THE ACCURACY OF YOUR MEDICAL AND/OR ACCIDENT HISTORY AND FURTHER CERTIFY THAT YOU PRESENT TO JU CHIROPRACTIC WELLNESS CENTER FOR EVALUATION AND TREATMENT OF A HEALTH RELATED CONDITION AND FOR NO OTHER PURPOSE.

Signature of Patient, or of Guardian Authorizing Care

Date