JU CHIROPRACTIC WELLNESS CENTER

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Confidential Patient Health Record

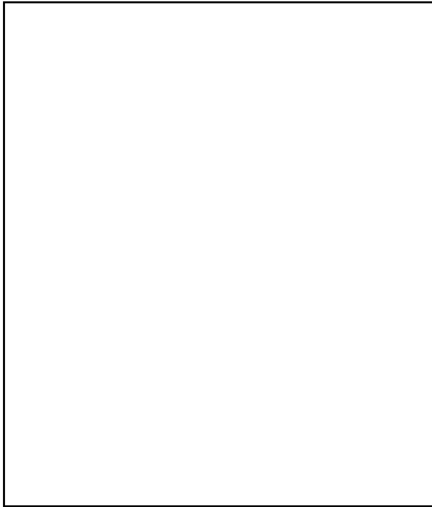
Last Name/First Name/ Middle Initial: ____ Date: ___________________
Home Ph#: ________________________ Cell Ph#: ________________________ Work Ph#: ______________________
Email Address: ____
Street Address: ____
City/State/Zip Code: ____
Date of Birth: _______________________ Age: ______________
Sex: ☐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