Confidential Patient Information **Date:**________________________

Name: ____ **Home Phone:** _________________
(Last) (First) (Middle)
Address:____ **Zip Code:** __________

Age: _______ **Birth Date:** __________ **Marital: M S W D** **How Many Children** __________

Occupation: __________________________ Employer**:** ____

Address: ____ **Office Phone:**_________________

Name of Wife or Husband:__________________________________ **Occupation:** ________________________

Patient's Nearest Relative: ______________________________________ **Phone:** ______________________

Referred by: ____

Have You Had Chiropractic Care before? ________ **When?** __________ **Where?** ________________________

Date of Last Physical Examination: _______________ **Date of Last Dental Examination:** _________________

What Operations Have You Had? _______________________________________ **When?** _________________

Serious Illnesses? ____ **When?** _________________

Have You Ever Suffered From:

- ❑ **Dizziness**
- ❑ **Backaches**
- ❑ **Heart Trouble**
- ❑ **Diabetes**
- ❑ **Tuberculosis**
- ❑ **Anemia**
- ❑ **Rheumatic Fever**
- ❑ **Nervousness**
- ❑ **Arthritis**
- ❑ **Headaches**
- ❑ **Numbness**
- ❑ **Asthma**
- ❑ **Neuritis**
- ❑ **Digestive Disorders**
- ❑ **Cancer**
- ❑ **Sinus Trouble**

Are You Pregnant? ( ) Yes ( ) No **Date of Last Period** ______________________

Purpose of this Appointment (Major Complaint): ____

Other Doctors Seen for this Condition: ____

Have you been treated for any health conditions by a physician in the last year ( ) Yes ( ) No
Describe: ____

What Medications or Drugs are you taking? ____

Remarks and Additional Information: ____

PAYMENT IS EXPECTED AT TIME OF VISIT

Name of Person Responsible for Payment ____

ARE YOU INSURED? ( ) Yes ( ) No Company: ____

I understand and agree that health and accident insurance policies are between an insurance carrier and myself. Further more, I understand that **Gorgas Chiropractic Clinic** will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to **Gorgas Chiropractic Clinic** will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. Should legal action be necessary for the recovery of any monies due under this agreement, the prevailing party shall be entitled to recover attorney fees and court costs from the other party. Interest of 1 1/2 % per month will be charged on delinquent accounts.

Patient's Signature: ___________________________**Soc. Sec. No.**____________________ **Date:** ____________

Personal Injury Questionnaire

Date of Accident: _____________ Hour: _______ AM/PM Location: __________________________________

How Did the Accident Occur: ( ) Auto Collision ( ) On – the – job Injury ( ) Other: ___________________

If Not An Auto Collision Please Describe Circumstances: ____
____

Did You Report the Injury to your Foreman or Employer? ( ) Yes ( ) No

Has This Part Been Injured Before? ( ) Yes ( ) No

If "Yes" State when and Describe: ____

If Auto Accident, Were You ( ) Driver ( ) Passenger ( ) Pedestrian

If Auto Collision Were You Struck From ( ) Behind ( ) Right Side ( ) Left Side ( ) Front

List the Extent of the Injury as You Know Them: ____

Where You Knocked Unconscious? ( ) Yes ( ) No

Did You Require Hospitalization After The Accident? ( ) Yes ( ) No If so, Where __________________

Where You Released the Same Day? ______________________ Attending Doctor _______________________

Where X-Rays Taken? ( ) Yes ( ) No

Check Symptoms You Have Noticed Since The Accident:

- ❑ **Headaches**
- ❑ **Neck Pain**
- ❑ **Neck Stiffness**
- ❑ **Sleeping Problems**
- ❑ **Back Pain**
- ❑ **Nervousness**
- ❑ **Tension**
- ❑ **Irritability**
- ❑ **Chest Pain**
- ❑ **Dizziness**
- ❑ **Head Seems Too Heavy**
- ❑ **Pins & Needles in Arms**
- ❑ **Pins & Needles in Legs**
- ❑ **Numbness in Fingers**
- ❑ **Numbness in Toes**
- ❑ **Shortness of Breath**
- ❑ **Fatigue**
- ❑ **Depression**
- ❑ **Lights Bother Eyes**
- ❑ **Loss of Memory**
- ❑ **Ears Rings**
- ❑ **Face Flushed**
- ❑ **Buzzing in Ears**
- ❑ **Loss of Balance**
- ❑ **Fainting**
- ❑ **Loss of Smell**
- ❑ **Loss of Taste**
- ❑ **Diarrhea**
- ❑ **Feet Cold**
- ❑ **Hands Cold**
- ❑ **Stomach Upset**
- ❑ **Constipation**
- ❑ **Cold Sweats**
- ❑ **Fever**
- ❑ **Other**

Symptoms Other than Above ____

Have You Lost Any Days of Work? ____________ Dates: ____

Insurance Companies Involved: My Company: __________________________________ Policy #: ___________
Company of Person Responsible for Injuries: ____________________________________ Policy #:___________

Have You Been Contacted By An Insurance Adjuster or Representative Regarding This Claim? ___________

Do You Have an Attorney That Has Advised You In This Case? ( ) Yes ( ) No

If so, Name of Attorney: _______________________ Address: _____________________ Phone: ____________

I Hereby Authorize Gorgas Chiropractic Clinic To Release Medical Information if Necessary to Process This Claim.

Signed: ____ Date: ____________________________