New Patient Enrollment Forms

Greetings,

At Optimum Health Chiropractic we take pride in the care for our patients. At every corner you will notice that we tailor to your needs and comfort. One of those ways is by making these forms available to you online. By making this packet available, we hope that this will reduce the wait time when visiting our clinic. Below you will find brief instructions on filing out this packet.

1. **Please fill out paperwork completely.**
2. **On the picture of the body, please put an "X" for pain and an "O" for numbness in the areas you are having trouble with.**
3. **List each complaint separately and as detailed as possible.**

Thank you very much for taking the time to fill these forms out before your first appointment and we also thank you for thinking of us when you are in need. We look forward to providing the absolute best care possible and exceeding your expectations!

Optimum Health Chiropractic Staff

OPTIMUM HEALTH CHIROPRACTIC

Automobile Accident Description

Name: ________________________________

Please answer All the questions below.

Acct #: ____________ Date: ____/____/____

1. Your vehicle type

☐ Car ☐ Large Truck
☐ Van ☐ Pickup Truck
☐ SUV ☐ Bus
Other ______________

2. Your position in vehicle

☐ Driver ☐ Front Passenger
☐ Left Rear Passenger
☐ Right Rear Passenger
Other ________________

3. What was your vehicle doing at the time of the accident?

☐ Stopped at intersection ☐ Stopped in traffic ☐ Stopped at light
☐ Making a right turn ☐ Making a left turn ☐ Parking
☐ Proceeding along ☐ Slowing down ☐ Accelerating
Other ____

4. Time/Speed/Damage

Date of accident ___/___/___
Time of accident __________
Your vehicle's speed: ____________mph
Their vehicle's speed: ____________mph
Damage to your vehicle:
☐ Mild ☐ Moderate
☐ Totaled

5. Details of Accident

Visibility at time of accident
☐ Poor ☐ Fair ☐ Good

Who hit who/what?
☐ You hit other vehicle
☐ Other vehicle hit you
☐ You hit…(object)
____

6. Road Conditions

Road conditions at time of accident
☐ Icy ☐ Wet ☐ Sandy ☐ Dark ☐ Clean and Dry

Point of impact (on your vehicle)
☐ Head-on ☐ Left Front ☐ Right Front
☐ Rear-end ☐ Left Rear ☐ Right Rear

7. Body Position, etc.

Did you see the accident coming? Yes ☐ No ☐
Were you braced for the impact? Yes ☐ No ☐
Did you have a seat belt on? Yes ☐ No ☐
Did you have a shoulder harness on? Yes ☐ No ☐

Does your vehicle have headrests? ☐ Yes ☐ No
What was the position of your headrest at the time of the impact?
☐ Even with top of head ☐ Even with bottom of head ☐ Middle of neck
What was the direction of your head at the time of the impact?
☐ Facing straight forward ☐ Turned to the right
☐ Turned to the left

8. Additional accident information

Enter any additional information you feel the doctor needs to know, that is not covered by the above check offs.

9. During the accident:

Did your body strike the inside of your vehicle? ☐ Yes ☐ No
If yes, describe: ____________________________________
Did you lose consciousness during the injury? ☐ Yes ☐ No
If yes, for how long? ________________________________
Your vehicle's estimated damage: ______________________
Damage to their vehicle: ☐ Mild ☐ Moderate ☐ Severe ☐ Totaled
Did police show up at the scene? ☐ Yes ☐ No
Was an accident report filled out? ☐ Yes ☐ No

10. After the accident:

Check off your symptoms right after and a few days following
☐ Headache ☐ Rib Pain ☐ Nausea ☐ Insomnia
☐ Neck Pain ☐ Arm Pain ☐ Irritability ☐ Depression
☐ Neck Stiffness ☐ Leg Pain ☐ Fatigue ☐ Fainting
☐ Mid back pain ☐ Dizziness ☐ Confusion ☐ Constipation
☐ Low back pain ☐ Ears ringing ☐ Nervousness ☐ Bladder/Bowel
☐ Arm Numbness L ☐ R ☐ ☐ Leg Numbness L ☐ R ☐
Others: ____
____

11. Emergency Room

Where did you go after the accident?
☐ Home ☐ Work ☐ Hospital ER ☐ Private Doctor
How did you get there?
☐ Drove self ☐ Somebody else ☐ Ambulance ☐ Police
Were x-rays done? ☐ Yes ☐ No Was lab work done? ☐ Yes ☐ No
Body parts x-rayed? ________________________________
What lab work? ____________________________________
The x-rays revealed: _______________________________
Treatments: ☐ Cervical collar ☐ Ice Other: ______________
Medications: ___________________________________
Follow-up instructions: ____________________________
____

12. Treatment History:

Fill in any other doctor(s) seen prior to your first visit to this office.
1. Dr. __________________________ First visit date: ____/____/____
Specialty: _______________________ X-rays done? ☐ Yes ☐ No
Types of treatments received: ___________________________________
How many treatments received? _________ Still treating? ☐ Yes ☐ No
Did treatments benefit you? ☐ Yes ☐ No
Last visit date: ____/____/____
2. Dr. __________________________ First visit date: ____/____/____
Types of treatments received: ___________________________________
How many treatments received? _________ Still treating? ☐ Yes ☐ No
Did treatments benefit you? ☐ Yes ☐ No
Last visit date: ____/____/____

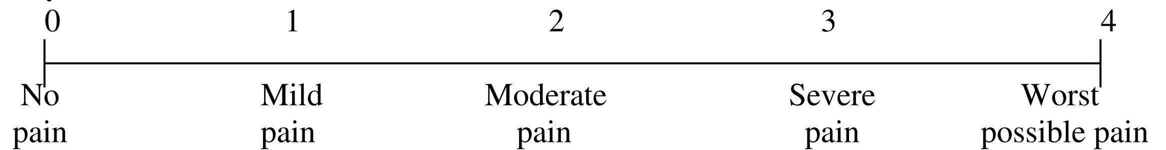
Patient Name_______________________________
Case # ____________ Date ____/____/____

Functional Rating Index

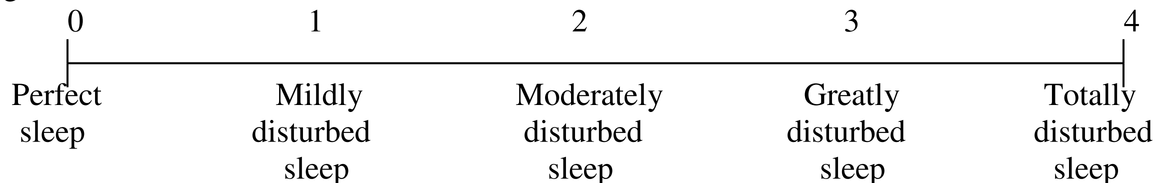
For Use with **Neck and/or Back Problems** only

In order to properly assess your condition, we must understand how much your Neck and/or Back problems have affected your ability to manage everyday activities.
For each item below, **please circle the number that most closely describes your condition right now**.

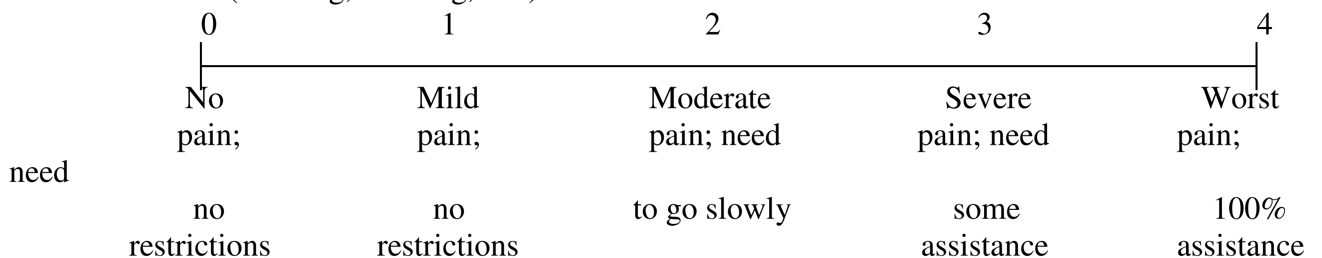
1. Pain Intensity



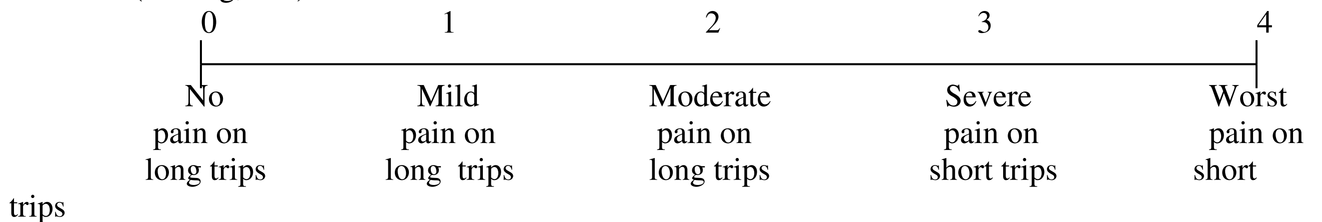
2. Sleeping



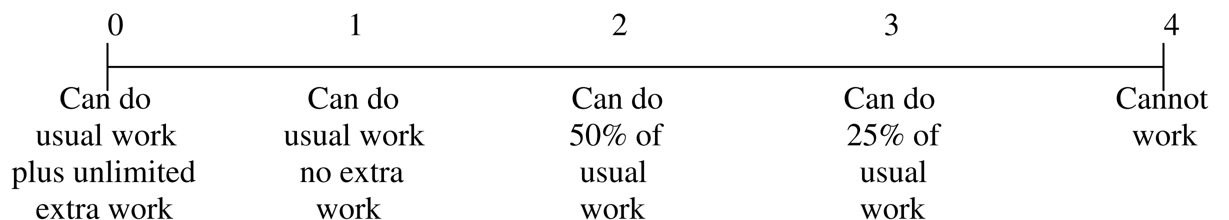
3. Personal Care (washing, dressing, etc.)



4. Travel (driving, etc.)



5. Work



6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

______________________________________ Patient's Signature

____/____/____ Date