Yen Chiropractic
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4528 W Craig Rd, Suite 190
North Las Vegas, NV 89032

General Information:

Today's Date: ________________

Patient Name: ____

Social Security #: ____

Address: ____

City: ____________________ State: ____________ Zip: _____________

Email: ____

Sex: ( ) Female ( ) Male

Birth date: _________________ Age: _________________

Height: ___________________ Weight: _______________

( ) Married ( ) Widowed ( ) Single ( ) Minor

( ) Separated ( ) Divorced ( ) Partnered for _____ Years

Home Phone: ______________________ Cell Phone: ______________________

Best time and place to reach you: ______________________________________

Occupation: ____

Patient Employer/School: ____

Employer/School Address: ____

____

Employer/School Phone: ____

How did you hear about us?: ____

In case of emergency, contact:

Name: ________________________ Relationship: _________________________

Home Phone: __________________ Cell Phone: __________________________

Information about the accident:

Date of Loss/Accident: __________________

Insurance Claim #: ______________________________________

Attorney Name & Phone: ____

DESCRIBE THE ACCIDENT IN DETAIL: ____
____
____
____

SPECIFICS OF THE ACCIDENT: (MARK EACH THAT APPLY TO THE ACCIDENT)

JOB/WORK RELATED INJURY:

( ) YES ( ) NO

YOU WERE THE:

( ) DRIVER ( ) PASSENGER

SITTING IN THE:

( ) FRONT SEAT ( ) BACK SEAT

BEFORE THE COLLISION, DID YOU:

( ) BRACE YOURSELF ( ) DID NOT BRACE YOURSELF

DURING THE COLLISION, DID YOUR HEAD:

( ) STRIKE AN OBJECT ( ) DID NOT STRIKE AN OBJECT

DURING THE COLLISION, DID YOU EXPERIENCE:

( ) SHOCK ( ) FLASH OF LIGHT SEEN UPON IMPACT

DURING THE COLLISION, DID YOUR AIR BAG:

( ) DEPLOY ( ) DID NOT DEPLOY

IMMEDIATELY FOLLOWING THE ACCIDENT (CHECK ALL THAT APPLY):

( ) AMBULANCE-PARAMEDICS CALLED

( ) TREATED AT SCENE

( ) TRANSPORTED TO HOSPITAL BY AMBULANCE

( ) WENT TO HOSPITAL ON OWN WILL

( ) DIAGNOSTICS PERFORMED AT HOSPITAL

( ) MEDICATION PRESCRIBED

( ) TREATMENT AT HOSPITAL

( ) A FOLLOW-UP WAS RECOMMENDED

Time Loss since the Accident:

( ) No time loss from work due to injury. I am currently working with no limitations.

( ) No time loss from work due to injury, But I do have limitations.

Please describe your limitations: ____

____

( ) I have experienced time loss from work due to injury.

Please indicate number of lost days, weeks, etc. ______________________________

____

( ) The above does not apply to me.

Mechanism of Injury:

Were you surprised by the impact? ( ) Yes ( ) No

In relation to the back of your head, was your headrest:

( ) Low ( ) Middle

( ) High ( ) None

Were you leaning forward at the time of the impact?

( ) Yes ( ) No

Were you wearing a seatbelt/harness?

( ) Yes ( ) No

Were you rendered unconscious as a result of the accident?

( ) Yes ( ) No

Did you feel pain immediately after the accident?

( ) Yes ( ) No

Did you lean your body towards the left or right before the impact?

( ) Yes ( ) No

List the year and type of vehicle you were in: ______________________________

____

Size of the vehicle you were in:

( ) Small ( ) Midsize ( ) Large ( ) Unknown

List the year and type of other vehicle involved in the accident: ____________

____

SIZE OF THE OTHER VEHICLE:

( ) SMALL ( ) MIDSIZE ( ) LARGE ( ) UNKNOWN

WHAT WAS THE APPROXIMATE SPEED OF YOUR VEHICLE WHEN THE ACCIDENT OCCURRED?

____

WHAT WAS THE APPROXIMATE SPEED OF THE OTHER VEHICLE WHEN THE ACCIDENT OCCURRED?

____

SOCIAL HISTORY:

NUMBER OF CHILDREN YOU HAVE: __________

( ) SMOKER ( ) NON-SMOKER

( ) DRINKS ALCOHOL ( ) DOES NOT DRINK ALCOHOL

( ) TAKES DRUGS ( ) DOES NOT TAKE DRUGS

LIST YOUR HOBBIES AND EXERCISE ACTIVITIES: _____________________________________

____

____

MEDICAL HISTORY:

I HAVE PREVIOUSLY SEEN THE FOLLOWING PHYSICIAN/PRACTITIONERS FOR THIS ACCIDENT:

CHIROPRACTOR: ____

MASSAGE THERAPIST: ____

NEUROLOGIST: ____

ORTHOPEDIST: ____

PHYSICAL THERAPIST: ____

PHYSICIAN: ____

PSYCHIATRIST/PSYCHOLOGIST: _______________________________________

OTHER: ____

CHECK THE TREATMENTS YOU HAVE ALREADY HAD FOR THIS CONDITION:

( ) ICE ( ) HEAT/ULTRASOUND ( ) ELECTRICAL STIMULATION ( ) EXERCISES

( ) GRAVITY INVERSION-TRACTION ( ) BED REST ( ) CHIROPRACTIC ( ) OSTEOPATHY

( ) INJECTIONS ( ) ACUPUNCTURE ( ) NATUROPATHY ( ) MASSAGE

IF ANY, LIST PREVIOUS BACK, NECK AND OTHER MUSCULOSKELETAL PROBLEMS:

____

____

____

HAVE YOU HAD ANY PREVIOUS OR SUBSEQUENT ACCIDENTS? IF SO, PLEASE LIST THE DATES THAT YOU LAST TREATED OR HAD COMPLAINTS: ____

____

____

SINCE THE MOST RECENT ACCIDENT DO YOU FEEL YOU ARE TROUBLED WITH:

( ) ANXIETY ( ) DEPRESSION ( ) IRRITABILITY

LIST CURRENT MEDICATIONS: ____

____

LIST PAST SURGERIES: ____

____

LIST PAST HOSPITALIZATIONS: ____

____

CHECK THE TYPES OF DIAGNOSTIC TESTING THAT HAS BEEN DONE FOR THIS ACCIDENT:

( ) X-RAYS ( ) CT SCAN ( ) MYELOGRAM ( ) MRI

( ) DISCOGRAM ( ) BONE SCAN ( ) EMG

FOR FEMALES ONLY:

ARE YOU PREGNANT: ( ) YES ( ) NO

CHECK IF YOU HAVE THE FOLLOWING:

( ) VAGINAL BLEEDING OTHER THAN A PERIOD

( ) PAP SMEAR WITHIN THE LAST 2 YEARS

( ) PAINFUL MENSTRUAL PERIODS

( ) BACK PAIN

( ) OTHER MENSTRUAL PROBLEMS

CHECK IF YOU HAVE EVER HAD ANY OF THE FOLLOWING SYMPTOMS:

( ) AIDS/HIV ( ) NEED TO URINATE MORE AT NIGHT

( ) ALCOHOLISM ( ) NIGHT SWEATS

( ) Allergy Shots
( ) Anemia
( ) Anorexia
( ) Appendicitis
( ) Arthritis
( ) Bleeding Disorders
( ) Blood in Stools
( ) Blood in Urine
( ) Breast Lump
( ) Bronchitis
( ) Bulimia
( ) Cancer
( ) Cataracts
( ) Change in Bowl Habits
( ) Chemical Dependency
( ) Chest Pain or Tightness
( ) Chicken Pox
( ) Coughing up Blood
( ) Diabetes
( ) Dark Black Stools
( ) Difficulty Sleeping
( ) Difficulty Urinating Start-Stop
( ) Dry Eyes or Mouth
( ) Easy Bruising
( ) Emphysema
( ) Epilepsy
( ) Excessive Bleeding
( ) Excessive Constipation
( ) Excessive Fatigue
( ) Fractures
( ) Glaucoma
( ) Goiter
( ) Gonorrhea
( ) Osteoporosis
( ) Pacemaker
( ) Pain/Burning when Urinating
( ) Parkinson's Disease
( ) Persistent Diarrhea
( ) High Blood Pressure
( ) High Cholesterol
( ) Joint Pain or Swelling
( ) Kidney Disease
( ) Liver Disease
( ) Loss of Appetite
( ) Lumps in Neck, Armpit or Groin
( ) Measles
( ) Migraine Headaches
( ) Miscarriage
( ) Mononucleosis
( ) Morning Stiffness
( ) Mumps
( ) Muscle Tenderness
( ) Persistent Eye Redness
( ) Persistent or Unusual Cough
( ) Pinched Nerve
( ) Pneumonia
( ) Polio
( ) Prostate Problem
( ) Prosthesis
( ) Psychiatric Care
( ) Rheumatoid Arthritis
( ) Rheumatic Fever
( ) Sexually Transmitted Disease
( ) Skin Rashes
( ) Stomach Pain
( ) Stroke

( ) Gout
( ) Heart Disease
( ) Hepatitis
( ) Hernia
( ) Herniated Disk
( ) Herpes
( ) Tuberculosis
( ) Tumors, Growths
( ) Typhoid Fever
( ) Ulcers
( ) Unexplained Fevers
( ) Unusual Stress at Home
( ) Unusual Stress at Work
( ) Vaginal Infections
( ) Weight loss of 10 lbs or more
( ) Whooping Cough
( ) Suicide Attempt
( ) Swollen Ankles
( ) Thyroid Problem
( ) Tonsillitis
( ) Trouble Breathing with Exercise
( ) Trouble Breathing with Lying Flat

Today's Date: ______________________________

Print your name: ____

Sign your name: ____

Print the guardian name if underage: ____

Signature of guardian if underage: ____