DR. ANDREA'S

CHIROPRACTIC
&
SPINAL DECOMPRESSION

Personal Injury Patient Registration

GENERAL INFORMATION

Title Mr./Mrs./Ms./Dr./Rev./Rank _____ Date: _____

Name: _____
LAST FIRST MI

What you prefer to be called: _____

Mailing Address: _____
CITY STATE ZIP

Mobile Phone #: _____ Home Phone #: _____

Work Phone #: _____ Other Phone(s) #: _____

E-Mail Address: _____

SS#: _____

Birth date: _____ Gender: ◯ Male ◯ Female Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Divorced

Employer Name: _____ Occupation: _____

Spouse Name: _____ Phone #: _____

Spouse's Employer: _____ Occupation: _____

INJURY INFORMATION

Date of injury: _____

Please write a brief description of how your injury occurred:

If your injury is NOT due to an automobile collision, please skip this section.

Were you stopped? ◯ Yes ◯ No If no, approximate speed: _____mph

Was the other vehicle stopped? ◯ Yes ◯ No If no, approximate speed: _____mph

At impact, was your body straight in your seat? ◯ Yes ◯ No If no, turned to the: ◯ Left ◯ Right

At impact, were you looking straight ahead? ◯ Yes ◯ No If no, was your head turned to the: ☐ Left ☐ Right ☐ Up ☐ Down

Were you aware that you were about to be hit? ◯ Yes ◯ No

Were you wearing a seatbelt at the time of the accident? ◯ Yes ◯ No

Did your ☐ Chest ☐ Head hit the steering wheel? ◯ Yes ◯ No

Did an airbag deploy? ◯ Yes ◯ No

Did your head hit the ☐ Windshield ☐ Side Window? ◯ Yes ◯ No

Did your shoulder hit the door? ◯ Yes ◯ No

Did your knees hit the dashboard? ◯ Yes ◯ No

Did the seat break? ◯ Yes ◯ No

Do you have any ☐ cuts ☐ bruises from the accident? ◯ Yes ◯ No If yes, where? _____

Was your car equipped with headrests? ◯ Yes ◯ No

If yes, at what height was the top of the headrest? ◯ Base of head ◯ Mid head ◯ Top of head

Did you lose consciousness? ◯ Yes ◯ No If yes, how long? _____

DR. ANDREA'S
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&
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Health Information

GENERAL INFORMATION

First Name: _____

Middle Initial:_____ Last Name: _____

Race:
- ☐ American Indian
- ☐ Alaska Native
- ☐ Asian
- ☐ White
- ☐ African American
- ☐ Other Pacific Islander
- ☐ Declined to State

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Declined to State

Preferred Language: _____

Email Address: _____

OFFICE USE ONLY

Account Number: _____

Patient Height: _____

Patient Weight: _____

Patient BMI: _____

Patient Blood Pressure: _____

Smoking Status:
- ☐ Current Every Day Smoker — Smoking Start Date: _____ End Date: _____
- ☐ Current Some Day Smoker
- ☐ Former Smoker
- ☐ Never Smoker
- ☐ In an effort to quit smoking, I am currently taking: _____

Do you have any allergies to medication? ◯ Yes ◯ No

If yes, please indicate the following:

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Are you currently taking any new medication since your last visit? ◯ Yes ◯ No

If yes, please indicate the following:

Medication: _____
Route: ☐ Oral ☐ Intravenous
Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

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Route: ☐ Oral ☐ Intravenous
Other: _____
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Began Use: _____
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