



**UPLAND
SPINE & REHABILITATION
CHIROPRACTIC CENTER**

CONFIDENTIAL PATIENT INFORMATION

Patient Name _____ Date ____/____/____
(First, Middle, Last)

Gender **M/F** Date of Birth ____/____/____ Current Age _____ SSN# _____

Address _____ City/State/Zip _____
Phone (____) _____ - _____ (____) _____ - _____
Home Cell Other

Email _____ Best reached by **EMAIL/PHONE/TEXT**

AUTO ACCIDENT INFORMATION

Date and time of accident ____/____/____ __ AM __ PM

Were you __ Driver __ Front pass __ Rear pass

Make and model of vehicle you were occupying _____

Did the police come to the accident site? **YES/NO**

Was a police report filed? **YES/NO**

Was a traffic violation issued? **YES/NO**

To whom was it issued? _____

Were there any witnesses? **YES/NO**

Number of people in your vehicle _____

Were you wearing a seatbelt? **YES/NO**

Did the airbags deploy? **YES/NO**

Was the headrest above or below the base of your skull? __ Above __ Below

What did your vehicle impact? _____

Did any part of your body strike anything in the vehicle? **YES/NO**

Make and model of other vehicle(s) involved _____

Location and street name on which you were traveling _____

In which direction were you headed? __ N __ S __ E __ W

Approximate speed of your vehicle _____

Was impact of your vehicle at __ Front __ Rear __ Right side __ Left side __ Other _____

During impact were you facing __ Front __ Right __ Left

Did you see car coming/have a chance to brace yourself? **YES/NO**

Were you surprised/caught off guard by impact? **YES/NO**

What direction was the other vehicle traveling? __ N __ S __ E __ W

Were you hit __ Head on __ Rear ended __ Other _____

Approximate speed of other vehicle _____

Please describe the accident in your own words _____



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AFTER INJURY

Did the accident render you unconscious? **YES/NO**

Please describe how you felt immediately after the accident _____

Have you gone to a hospital or seen any other doctor? **YES/NO**

Name of doctor _____

When did you go to the hospital? Just after the accident The next day 2+ days Other _____

How did you get there? Ambulance Private transportation

Name of hospital and/or attending doctor _____

Was he/she a MD DO DC DDS

Describe the type of treatment you received _____

Were X-Rays taken? **YES/NO**

Was medication prescribed? **YES/NO** _____

Have you been able to work since the injury? **YES/NO**

Are your work activities restricted as a result of this injury? **YES/NO**

Indicate the symptoms that are a result of this accident

Dizziness Memory loss Headaches Blurred vision Buzzing in ear Ears ringing

Difficulty Sleeping Irritability Fatigue Tension Neck pain Neck stiffness Jaw problems

Arm/shoulder pain Numb hands/fingers Chest pain Shortness of breath Stomach upset

Nausea Back pain Lower back pain Back stiffness Leg pain Numb feet/toes

Is your condition getting worse? YES NO CONSTANT COMES AND GOES

Level of comfort while performing the following activities

	Comfortable	Uncomfortable	Painful
Lying on back			
Lying on side			
Lying on stomach			
Sitting			
Standing			
Stretching			
Lovemaking			
Walking			
Running			
Sports			
Working			
Lifting			
Bending			
Kneeling			
Pulling			
Reaching			

Have you retained an attorney? **YES/NO**

If yes, whom? _____

Attorney phone number _____



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RECOVERY

How many hours are in your normal workday? _____

Please indicate your daily job duties and any activities which you are occasionally asked to perform

Standing Sitting Walking Lifting Driving Twisting Crawling Bending
 Operating equipment Work with arms above head Typing Stooping

What positions can you work with a minimum physical effort and for how long? _____

Prior to injury were you capable of working on an equal basis with others your age? YES/NO N/A

Do you work with others who can help you with any heavy lifting? YES/NO N/A

Is there any light duty work you could request while in recovery? YES/NO N/A

Upland Spine & Rehab invites you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at time of visit, unless arrangements have been made. If accounts are not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting the account.

I authorize the staff at Upland Spine & Rehab to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient (Parent/Legal Guardian) Name

Patient (Parent/Legal Guardian) Signature

Date