



FRED C. NELSON, D.C., C.C.S.P.
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Welcome to our office!

*To insure your
first visit with us
is a pleasant one,
here are the
procedures you
can expect
during the next
50 minutes
with us.*

Paperwork

Complete this brief questionnaire to help us get to know you. The doctor will use this information to help formulate the recommendations for your care.

Patient Education

To acquaint you with our office and explain how we help our patients regain their health.

Consultation

You'll meet the doctor who will review your health history and determine if yours is a chiropractic case.

Examination

Standard physical, orthopedic, neurological, and chiropractic tests will be performed to determine the cause(s) of your problem.

X-ray Exam

Necessary views may be taken to visualize the location of any spinal problems, reveal any pathologies, and make your chiropractic care more precise.

Correlation

Before proper care can be rendered the Doctor will study your examination findings.

Adjunctive Procedures

The doctor may suggest the application of ice, heat, or the use of some other procedure to help reduce inflammation and make you more comfortable.

Next Visit

Your first visit is complete. Plan to spend about 45 minutes on your next visit to receive the Doctor's report of findings and chiropractic care.



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AUTO ACCIDENT INTAKE FORM

PLEASE PRINT THE FOLLOWING INFORMATION: DATE: _____

FULL, LEGAL NAME: _____ NICKNAME: _____

DATE OF BIRTH: ____/____/____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: (H) _____ (W) _____ (OTHER) _____

MAY WE CALL YOU AT WORK (Circle one)? YES NO EMPLOYER: _____

AGE: ____ GENDER: ____ MARITAL STATUS (Circle one): MARRIED SINGLE DIVORCED OTHER

SPOUSE'S NAME (If applicable): _____ NUMBER OF CHILDREN: _____

PLEASE PROVIDE THE FOLLOWING INFORMATION REGARDING THE ACCIDENT:

DATE: _____ TIME: _____ AM/PM CITY: _____ STATE: _____

Were you the (Circle one): Driver Front Passenger Left Rear Passenger Right Rear Passenger Pedestrian

Were you wearing your seatbelt (Circle one)? YES NO Were you (Circle one): prepared for impact caught by surprise

At the time of impact, was your vehicle (Circle one): stopped in motion If moving, estimate how fast (mph): ____

Were you hit from the (Circle one): Front Left Side Right Side Rear Did the airbag deploy (Circle one)? YES NO

Did the vehicle flip over (Circle one)? YES NO Were you thrown out of your seat (Circle one)? YES NO

Which objects in the vehicle did your body strike (Specify the body part that made contact)? _____

Describe in detail, how the accident occurred: _____

Did you feel immediate pain (Circle one)? YES NO If yes, where? _____

Did you receive any cuts or lacerations (Circle one)? YES NO If yes, where? _____

Did you lose consciousness (Circle one)? YES NO If yes, for how long? _____

Did you go to the emergency room/hospital after the accident (Circle one)? YES NO NAME: _____

Were you (Circle one): Taken by ambulance Driven by another person Able to drive yourself

Were X-Rays taken (Circle one)? YES NO List Diagnosis and Treatment received: _____

List any medications: _____

Has any other doctor been consulted (Circle one)? YES NO NAME: _____

List any treatment that was given: _____

How often did you see the doctor? _____ Are you still treating with him/her (Circle one)? YES NO

How much property damage did the vehicle sustain (Circle one)? Minimal Moderate Extensive Totaled

What are your chief complaints for today's visit? _____

Have you ever had any similar complaints or injuries before (Circle one)? YES NO If yes, explain: _____

What actions aggravate your symptoms? _____

What actions relieve your symptoms? _____

Have you ever had any surgeries (Circle one)? YES NO If yes, specify: _____

Have you lost any time from work since the accident (Circle one)? YES NO How much? _____ Dates: _____

Are you presently working (Circle one)? YES NO Are you presently on disability (Circle one)? YES NO

Last date worked: _____ Describe your job duties: _____

COVERAGE

Did the Auto Accident occur while working on the job (Circle one)? YES NO

If yes, has the accident been filed as Worker's Compensation (Circle one)? YES NO Employer's Name: _____

Were the police notified (Circle one)? YES NO Was a police report made (Circle one)? YES NO

Do you have a copy of the police report (Circle one)? YES NO **IF YES, PLEASE PROVIDE US WITH A COPY

Who was cited as the liable driver (the person responsible for the accident)? _____

Was Insurance Information exchanged (Circle one)? YES NO **IF YES, PLEASE PROVIDE US WITH A COPY

LIABILITY INFORMATION:

Has the accident been reported to the liability insurance company (Circle one)? YES NO

Insurance Carrier: _____ Phone: _____ Name of Adjuster: _____

Name of Insured: _____ Policy #: _____ Claim #: _____

Has the Liability Carrier paid for your vehicle damage (Circle one): YES NO

MEDPAY INFORMATION:

Has the accident been reported to your Auto Insurance Company (Circle one)? YES NO

Do you have medical payments coverage (MedPay) on your Auto Insurance plan (Circle one)? YES NO

Have you received any benefits from your Auto Insurance Company yet (Circle one)? YES NO

Insurance Carrier: _____ Phone: _____ Name of Adjuster: _____

Name of Insured: _____ Policy #: _____ Claim #: _____

ATTORNEY REPRESENTATION:

Have you retained an Attorney (Circle one)? YES NO NAME: _____ Phone: _____

ADDRESS: _____

PERSONAL HEALTH INSURANCE:

Carrier: _____ ID #: _____ Group #: _____

Insured's Name: _____ Insured's Date of Birth: _____ Relationship: _____

PATIENT NAME: _____ **DATE:** _____

PATIENT SIGNATURE: _____