

# Application for Treatment

## General Information

Name : \_\_\_\_\_  
Address : \_\_\_\_\_  
City/Zip : \_\_\_\_\_  
Home phone # : \_\_\_\_\_  
Social Security # : \_\_\_\_\_  
Birth date : \_\_\_\_\_  
Occupation : \_\_\_\_\_  
Employer : \_\_\_\_\_  
Work phone # : \_\_\_\_\_  
Spouse : \_\_\_\_\_  
Spouse's employer : \_\_\_\_\_  
Spouse's work # : \_\_\_\_\_  
Emergency contact : \_\_\_\_\_  
Today's date : \_\_\_\_\_  
Date of injury : \_\_\_\_\_

## Past Medical History

Surgeries and dates: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Fractures and dates: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Serious illnesses and dates: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Other injuries: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Any history of current complaints and dates: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Prior chiropractic treatment and dates: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Current Medical History

Any Current health problems \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Any Current medications \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Are you pregnant?  
 Yes  No

## General Injury History

Was this crash on the job?  Yes  No  
You were:  Driver  Front passenger  Rear passenger  Other  
Vehicle driven by: \_\_\_\_\_  
Your vehicle(yr,make,model): \_\_\_\_\_  
\_\_\_\_\_  
Estimated speed at moment of crash: \_\_\_\_\_  
 Stopped  Slowing  Accelerating  
Other vehicle(yr,make,model): \_\_\_\_\_  
Time of day: \_\_\_\_\_  
Road conditions:  Dry  Damp  Wet  Snow  Ice  other  
Seatbelt:  Wearing  Not wearing  
Did the airbag deploy: Yes  No  NA  
Where were you looking on impact:  
straight ahead  Up  Down  Right  Left  
Combination of two  
Braced for impact:  Yes  No  
Hands:  One on wheel  Two on wheel  
Brakes applied:  Yes  No  
In your own words, describe what happened \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Were you aware that the crash was about to take place:  Yes  No

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## Crash diagram:

## During the crash

Did any of your body strike any parts of the vehicle:  Yes  No

If yes, what part of your body struck what part of the car: \_\_\_\_\_

Did your car strike anything after the initial impact:  Yes  No

Wearing hat or glasses:  Yes  No

If yes, still on after crash:  Yes  No

Did you lose consciousness:  Yes  No

Was the police called  Yes  No

Was a report made:  Yes  No

## Hospital visit

Xrays taken:  Yes  No

If yes, what body part: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Lab work:  Yes  No

Braces or supports:  Yes  No

Medications:  Yes  No