

Clayton Chiropractic

5685 S 1475 E Suite 2A South Ogden, UT 84403

Phone (801)621-1668 Fax (866)723-7266

Today's date _____

First Name _____ Middle Initial _____ Last Name _____

Birth date _____ Height _____ Weight _____ Gender: M F

Address _____

Phone number _____ E-Mail address _____

Occupation _____ Have you seen a chiropractor before: Y N

Are you pregnant: Y N N/A

Please list any allergies (including allergies to medications):

Please list any surgeries you have had:

Please list your past medical history, i.e. cancer, high blood pressure, diabetes, heart conditions, stroke, osteoporosis, etc.:

Please list any medications you are taking and reason for taking them:

Please list any relevant family history, i.e. cancer, high blood pressure, diabetes, heart conditions, stroke, osteoporosis, etc.:

Please list any injuries or traumas you have had, i.e. car accident, work injury, sports, etc.:

Review of Systems

Neurologic-

- Dizziness
- Fainting
- Seizures
- Weakness
- Numbness
- Tingling
- Tremor
- None of the above

General-

- Unexpected weight loss
- Fever
- Loss of appetite
- Fatigue
- Feeling generally sick
- None of the above

Eyes-

- Sensitivity to light
- Visual disturbances
- Blurred vision
- None of the above

Ears-

- Decreased hearing
- Ringing in ears
- Earache
- Drainage
- None of the above

Nose-

- Stuffiness
- Discharge
- Itching
- Hay fever
- Nosebleeds
- Sinus pain
- None of the above

Throat-

- Bleeding
- Dentures
- Sore tongue
- Dry mouth
- Sore throat
- Hoarseness
- Thrush
- Non-healing sores
- None of the above

Cardiovascular-

- Palpitations
- Shortness of breath
- Chest pain
- Chest tightness
- None of the above

Respiratory-

- Cough
- Shortness of breath
- Painful breathing
- Wheezing
- None of the above

Gastrointestinal-

- Swallowing difficulties
- Heartburn
- Change in appetite
- Nausea
- Change in bowel habits
- Rectal bleeding
- Constipation
- Diarrhea
- None of the above

Urinary-

- Frequency
- Urgency
- Burning or pain
- Blood in urine
- Incontinence
- Change in urinary strength
- None of the above

Skin-

- Rashes
- Lumps
- Itching
- Dryness
- Color changes
- Hair and nail changes
- None of the above

Psychiatric-

- Nervousness
- Stress
- Depression
- Memory loss
- None of the above

Clayton Chiropractic

5685 S. 1475 E. Suite 2A South Ogden, UT 84403

Phone (801)621-1668 Fax (866)723-7266

Auto accident questionnaire

Name _____

Date:

Auto accident date : _____ Time of accident: _____

Type of vehicle you were in _____

Did you have your seatbelt on?

Did the airbags go off?

Did you have your head turned or looking straight ahead during the collision?

Were you the:

Driver

Both hands on the wheel

Right hand on the wheel

Left hand on the wheel

Driver of a motorcycle

Front Passenger

Back Passenger

Other: _____

What was your vehicle doing at the time of the accident i.e. stopped at a light, slowing down, etc.?

What was the first area of impact for your vehicle?

If accident involved another vehicle, please describe the opposing vehicle type:

Approximate speed of the opposing vehicle _____

Approximate speed of your vehicle _____

Were you aware the impact was coming and able to brace?

Which position was your headrest in? Middle High Low Unknown

Clayton Chiropractic

5685 S. 1475 E. Suite 2A South Ogden, UT 84403

Phone (801)621-1668 Fax (866)723-7266

How did you feel after the accident?

Did you go to the Hospital: Y N

If so, were you admitted: At time of accident At a later time

Transported to hospital: Ambulance Life Flight Police Car Private

Transportation

What hospital did you go to?

How were you injured?

- | | | |
|---|--|---|
| <input type="checkbox"/> Thrown from Vehicle | <input type="checkbox"/> By seatbelt | <input type="checkbox"/> Hit another passenger |
| <input type="checkbox"/> Hit back of front seat | <input type="checkbox"/> Hit console | <input type="checkbox"/> Hit dashboard |
| <input type="checkbox"/> Hit the door | <input type="checkbox"/> Hit the roof of car | <input type="checkbox"/> Hit the steering wheel |
| <input type="checkbox"/> Hit window | <input type="checkbox"/> Hit windshield | <input type="checkbox"/> Other _____ |

Please list all medical facilities you have been to for this accident:

Are you able to work?

Are you able to perform household chores?

Are you experiencing any of the following since the accident?

- | | | |
|--|---|--|
| <input type="checkbox"/> Visual disturbances | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Sensitivity to light | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Memory loss | <input type="checkbox"/> None of the above |