Marshall County Chiropractic
142 VINE STREET
BENTON, KY 42025

TELEPHONE: (270) 527-0000
FAX: (270) 527-2121

Today's Date: _____/_____/_____

Name: _____What do you prefer to be called: _____

Mailing Address: _____City: _____ST: _____Zip: _____

Date of Birth: ____/_____/_____ SS#: _____Marital Status: M____ S____ W____ D___

Home Phone: (_____) _____ Cell Phone: (_____)_____

Employer: _____ Work Phone: (_____)_____

Emergency Contact:_____Relation:_____Phone:(____)_____

Who may we thank for referring you to our office:_____

INSURANCE INFORMATION

Policy Holders Name: _____ Relationship: _____

Birthdate: _____/_____/_____ Employer: _____

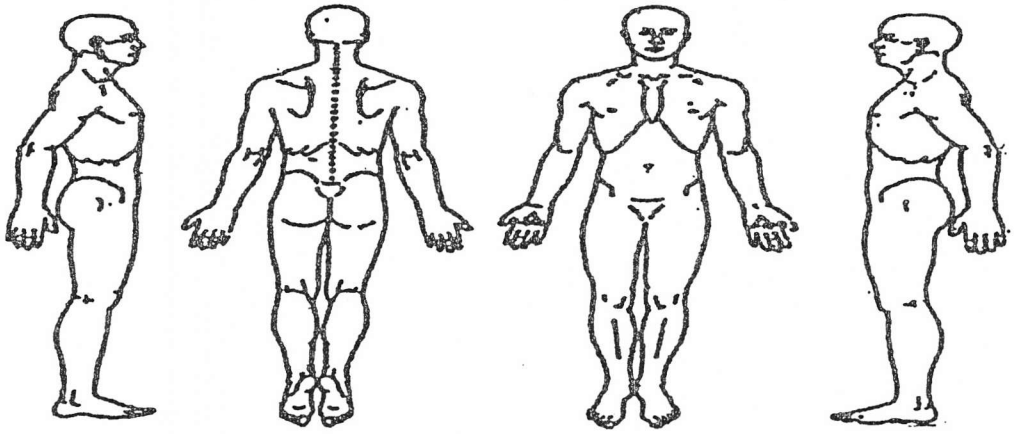
PATIENT INTAKE FORM

Patient Name (please print):_____ Date:_____

Occupation: _____

1. Is today's problem caused by: Auto Accident: Yes No Workman's Compensation: Yes No

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- □ Constantly (76-100% of the time)
- □ Frequently (51-75% of the time)
- □ Occasionally (26-50% of the time)
- □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- □ Sharp
- □ Dull
- □ Diffuse
- □ Achy
- □ Burning
- □ Shooting
- □ Stiff
- □ Numb
- □ Tingly
- □ Sharp with motion
- □ Shooting with motion
- □ Stabbing with motion
- □ Electric like with motion
- □ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Significantly

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Significantly

9. Who else have you seen for your problem?

- □ Chiropractor
- □ ER physician
- □ Massage Therapist
- □ Neurologist
- □ Orthopedist
- □ Physical Therapist
- □ Primary Care Physician
- □ Other:_____
- □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What gives you relief, or makes problem better?

_____

14. What aggravates your problem?

_____

15. What concerns you the most about your problem; what does it prevent you from doing?

_____

16. What is your: Height_____ **Weight** _____ **Date of Birth** _____

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Patient Name (please print):_____Date:_____

17. How would you rate your overall health? □ Excellent □ Very Good □ Good □ Fair □ Poor

18. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

19. Indicate if you have any immediate family members with any of the following (including grandparents):

□ Rheumatoid Arthritis_____ □ Diabetes _____ □ Lupus_____ Other_____

□ Heart Problems _____ □ Cancer_____ □ ALS_____ Other_____

20. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependence
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:_____				

21. List all prescription medications you are currently taking (we can copy a list if you have one):

_____

22. List all of the over-the-counter medications you are currently taking:

_____

23. List all surgical procedures you have had (include dates):

_____

24. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

25. What activities do you do outside of work?

_____

26. Have you ever been hospitalized? □ No □ Yes
If yes, why/when _____

27. Have you had significant past trauma, broken bones, and/or accidents? □ No □ Yes
If yes, what/when_____

28. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date**_____

----------DO NOT WRITE BELOW THIS LINE----------

Doctor's Notes:_____

_____

_____

Motor Vehicle Collision Form

Patient Name (please print): _____ Date: _______________

1. What was the date of the MVC? _______________
2. What time did the MVC occur? _____:_____ am / pm
3. Enter the number of vehicles involved in the MVC:

   ____1 ____2 ____3 ____4____5____6____7____8____9
4. In Dollars, please enter the estimated damages to your vehicle $ _____
5. What road were you on? _____
6. What direction were you traveling?

NW	N	NE	W	E	SW	S	SE

7. What city & state were you traveling? _____
8. Did the airbag deploy? ___ Yes ___ No
9. Please choose the primary type of impact:

Vehicle was rear ended	Vehicle hit another from behind	Vehicle was hit head on	Vehicle was hit on driver's side	Vehicle was hit on passenger side

10. What did the vehicle do immediately after the accident?

Hit a guard rail	Hit a tree	Rolled Over	Was ran off the road	Other:

11. Where were you sitting in this vehicle?

Driver	Rear Left Passenger	Rear Passenger
Front Passenger	Rear Right Passenger	Other:

12. Did you know the accident was coming?

Was unaware of the impending collision	Was aware of the impending collision and braced
Was aware of the impending collision and relaxed	Other:

13. What was the type of vehicle you were in?

Subcompact car	Compact car	Mid-size car	Full-size car	Truck
SUV	Minivan	Van	Larger than one ton Vehicle	Other:

Other: _____

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Motor Vehicle Collision Form

Patient Name (please print): _____ Date: _______________

14. At the time of impact, your vehicle was:

Slowing down	Gaining speed	Stopped	Moving at a steady speed

15. At impact the other vehicle involved was:

Slowing down	Gaining speed	Stopped	Moving at a steady speed

16. During the crash, what happened to your vehicle?

Kept going straight	Kept going straight hitting a car in front	Was it by another vehicle
Spun around	Spun around and hit a stationary object	Other:

17. Did you lose consciousness during the accident?

Lost consciousness during the accident	Remained conscious throughout entire accident

Other: _____

18. How was your head positioned during the accident?

Head facing forward	Head turned to the left	Head turned to the right	Head facing upward	Head facing downward
Head facing to the right and upward	Head facing to the right and downward	Head facing left and upward	Head facing left and downward	Other:

Other: _____

19. How was your torso positioned during the accident?

Torso positioned forward	Torso positioned to the left	Torso positioned to the right	Torso extended	Torso flexed
Torso flexed with right rotation	Torso extended with right rotation	Torso flexed with left rotation	Torso extended with left rotation	Other:

Other: _____

20. How were your hands positioned during the accident?

Left hand on the steering wheel	Right hand on the steering wheel	Both hands on the steering wheel	Left hand on the dashboard	Right hand on the dashboard
Both hands on the dashboard	Hand on the seat in front	Hands resting along side	Hands on ceiling of the car	Other:

Other: _____

Motor Vehicle Collision Form

Patient Name (please print): _____ Date: _______________

21. Did your head hit any of the following?

Windshield	Steering wheel	Side door	Dashboard	Ceiling
Car frame	Another passenger	Seat	Side window	Other:

22. Did your face hit any of the following?

Windshield	Steering wheel	Side door	Dashboard	Ceiling
Car frame	Another passenger	Seat	Side window	Other:

23. Did your shoulders hit any of the following?

Windshield	Steering wheel	Side door	Dashboard	Ceiling
Car frame	Another passenger	Seat	Side window	Other:

24. Did your neck hit any of the following?

Windshield	Steering wheel	Side door	Dashboard	Ceiling
Car frame	Another passenger	Seat	Side window	Other:

Other: _____

25. Did your chest hit any of the following?

Windshield	Steering wheel	Side door	Dashboard	Ceiling
Car frame	Another passenger	Seat	Side window	Other:

Other: _____

26. Did your hips hit any of the following?

Windshield	Steering wheel	Side door	Dashboard	Ceiling
Car frame	Another passenger	Seat	Side window	Other:

Other: _____

27. Did your knees hit any of the following?

Windshield	Steering wheel	Side door	Dashboard	Ceiling
Car frame	Another passenger	Seat	Side window	Other:

Other: _____

Motor Vehicle Collision Form

Patient Name (please print): _____ Date: _______________

28. Did your feet hit any of the following?

Windshield	Steering wheel	Side door	Dashboard	Ceiling
Car frame	Another passenger	Seat	Side window	Other:

Other: _____

29. What kind of headrests were in your vehicle?

Movable fixed head restraints	Fixed, non-movable head restraints	No head restraints

Other: _____

30. Where was your headrest positioned on your head?

At the top of the back of neck	At the middle height of the back of head	At the lower portion of the back of head
At the level of the back of neck	At the level of the shoulder blades	

Other: _____

31. Did you have your seatbelt on?

Was wearing a shoulder strap seat belt	Was wearing a lap belt seat belt	Was in a baby car seat
Was not wearing a seatbelt	Cannot remember if had a seatbelt on	Was in a booster seat

Other: _____

32. Did you slide out of your seat belt?

Slid out of seatbelt	Remained in seatbelt	Partially slid out of seatbelt

Other: _____

33. What was damaged in your vehicle?

Windshield	Steering wheel	Dashboard	Seat frame
Side window	Rear window	Mirror	Knee bolster
Rear bumper	Trunk	Completely totaled	Front left door
Front right door	Back left door	Back right door	none

Other: _____

34. Choose the items that dented inward during the accident?

Side door	Dashboard	Floor board	None

Other: _____

Motor Vehicle Collision Form

Patient Name (please print): _____ Date: _______________

35. Choose the doors that would not open as a result of the accident:

Side door (which one) _____	Hood	Trunk	none

Other: _____

36. How did you go the hospital?

Ambulance	Helicopter	Police car
Drove yourself	Someone drove me to hospital	N/A (Did not go to hospital)

37. Please choose the locations of the problems you are having:

Headaches	Jaw	Neck	Upper back	Shoulder
Arm	Elbow	Wrist	Hand	Mid back
Low back	Hip	Legs	Knee	Ankle
Foot	Other:	Other:	Other:	Other:

38. Were you hospitalized overnight? ___ Yes ____ No ____N/A

39. At the hospital, were you prescribed pain medication? ___ Yes ____ No ____N/A

40. Were you prescribed muscle relaxers at the hospital? ___ Yes ____ No ____N/A

41. Did you receive stitches for any cuts? ___ Yes ____ No ____N/A

42. Did you receive any of the following? ___ Yes ____ No ____N/A

Cervical Collar	Back Brace	Cervical collar and Back Brace	N/A

43. Which x-rays were taken at the hospital?

Skull	Neck	Mid back	Lower back	Foot	Arm
Pelvis	Hips	Leg	Knee	Shoulder	No x-rays

44. Was an MRI performed?

Skull	Neck	Mid back	Lower back	Foot	Arm
Pelvis	Hips	Leg	Knee	Shoulder	No MRI

Other: _____

45. Did you receive any other special imaging? ____ Yes ____ No If yes, what type? _____

Skull	Neck	Mid back	Lower back	Foot	Arm
Pelvis	Hips	Leg	Knee	Shoulder	Other: