Cooper Chiropractic
Acupuncture and Rehab Center
1501 Robert J. Conlan Blvd.
Suite 3
Palm Bay, FL 32905
321-726-8116

PATIENT INITIAL INTAKE / EXAM FORM
PIP ACCIDENT

Today's date :(m/d/y)____/____/___. **Examination date :(m/d/y)____/___/____.**
Date of Accident : (m/d/y)____/___/____.

Last Name :__________________________.
First Name :__________________________.
Middle Initial:________________________.
Home Address:_____________________________City:____________________State:_____.
Zip Code:____________________.
E-Mail Address : ____.
Home Phone: (____)_____-________.
Cell phone:(____)______-________.

Employer:____.
Work phone :(____)_____-______.
Type of work :____.

Gender: Male / Female

Social Security Number: ________-_________-_____________.
Drivers License Number:_______________________________.
Date of Birth (m/d/y) : ________-_________-___________.
Marital Status : Married / Single / Widow(er) / Divorced
Emergency Contact :(Name)______________________. Phone N0. :(___)_____-________.
****

****How did you hear about our office : ____.**

Insurance Provider :____.
Policy number:____.
Claim No. :____.
Phone number :_1 (______)_________-_____________.
Do you have copy of accident report : Y / N. If yes please bring in a copy.

Pat. Name :_____.

CHIEF COMPLAINTS : Place A Check Next To The Conditions Which Describe Your Complaints Today.

_____Headaches (back of the head) (front of the head) (Sides of the head / R / L / Both)
_____Dizzy Spells * _____Ringing in the Ears * _____Blurred Vision

_____Jaw Joint pain (R / L / BOTH) _____Clicking/Cracking in the Jaw Joints

_____Neck pain (Upper/ Middle/ Lower)
_____Shoulder Pain (Right/ Left/ Both)
_____Pain into the Arms (Right/ Left/ Both)
_____Numbness and Tingling into the Arms/Hands (Right/ Left/ Both)

_____Mid Back Pain (Above the shoulder blades/ Between the shoulder blades/ Below the shoulder blades) R / L / BOTH

_____Lower Back Pain(Above the belt/ At the belt level/ Below the belt/ Tailbone area) Right / Left / Both

_____Pain Down the Legs (Right/ Left/ Both) Thigh (s) Calf (s) Foot/Feet

_____Numbness and Tingling affecting the Legs (Right/ Left/ Both) Thigh(s) -- Calf(S) -- Foot/Feet)

Any bruises Y / N where_____.
Any lacerations or cuts Y /N where _____.

PAIN RATING :
Please rate your Pain based on the following scale of 0 to 10.
0 = no Pain / 1-3 = mild / 4-6 = moderate / 7-10 = severe
AREA / REGION :
NECK :_____ MID BACK : _____ LOW BACK :_____
ARMS – R:_____ L :_____ SHOULDERS: R _____ L _____
LEGS R _____ L _____
OTHER : _____. Is Pain constant : Y/ N

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PAT NAME_____

HISTORY OF ACCIDENT :

Date of accident:_____ Time of Day : _____AM / PM.
Where did accident occur : city _____.
Are you the car owner Y / N. If no : Name of car owner_____.
Make and Model of car :_____.
Road Conditions : wet / dry. You're traveling North / South / East / West
On what road :_____.
Were you the Driver / Passenger.
If passenger where were you sitting :_____.
Did you have a seat belt on : Y / N. Did you have a shoulder harness : Y / N.
Did you see the accident coming : Y/ N. Did you brace for the accident : Y / N.
Did the other car hit you : Y / N. Did you hit the other car : Y / N.

Please describe in your own words how the accident happened :_____
_____
_____
_____
_____
_____
_____
_____.
if you need more room please use back of this sheet.

When you were hit were you thrown : forwards / backwards / to the side.
Did you hit anything with your body IE : steering wheel / dashboard / drivers door / passenger door / door frame / other passengers / other_____.

Was your car spun around at all on impact : Y / N. If yes how much :_____.
Did your car flip over : Y / N . If yes how many times :_____.

Immediately after the accident :
Did you feel immediate pain: Y / N. Was your Pain gradual in onset : Y / N.

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Patient Name :_____

Describe how your Pain developed IE : where did you hurt first and then where did you hurt next and so on :_____
_____
_____.

Were you knocked out at all : Y / N. If yes how long : _____.
Was there a period of time when you are not sure what was going on : Y / N .
If yes how long : _____.

Were the EMS/paramedics called : Y / N. Did they examine you : Y / N.
Were you put on a stretcher / backboard : Y/ N. Were you taken to the hospital : Y/ N
If yes which hospital : _____.
At the hospital were x-rays taken : Y / N.
If yes what areas :_____.
Were you admitted to the hospital : Y / N. If yes for how long : _____.
Were you prescribed any medications : Y / N. Are you still taking your medications : Y / N.

Have you returned to work : Y/ N.
If no how long have you been out of work due to the injuries from your accident :_____.

Was a police report filed : Y/ N. What Police Department : _____.
Did you get a copy of the accident report : Y/ N. If Yes Please Bring In A Copy.

What efforts at self treatment have you tried in order to relieve the symptoms/Pain:
Please describe: _____
_____.

Have you seen any other doctors for your injuries : Y / N. If so please list in the order seen with their specialty :
Dr. _____. Date first seen_____. Still Treating : Y / N.
Dr. _____. Date first seen_____. Still Treating : Y / N.
Dr. _____. Date first seen_____. Still Treating : Y / N.
Dr. _____. Date first seen_____. Still Treating : Y / N.
****

Patient Name :_____.

DAILY ACTIVITIES :

We need to know what activities bring on your pain, aching, numbness and tingling/pins and needle sensations, or any discomforts or restrictions because of your injuries.
Place a check mark by any activity which causes the above and write in where the pain or discomfort occurs:

_____Reading : _____. ____Book/computer work:_____.
_____Arms raised overhead :_____.
_____Doing work overhead :_____.
_____Driving:_____.
Does it now bother you to drive after your accident : Y / N.
_____Lifting:_____. _____Bending :_____.
_____Stooping:_____. _____Standing:_____.
_____Sitting for long periods:_____.
_____Walking for long periods :_____.
Other activities :_____
_____.

What recreational activities are you unable to do as a result of your injuries_____
_____
_____.

What personal activities(shaving, getting dressed,etc.) are restricted or you can no longer do because of your injuries :_____
_____
_____.

Explain how your work has been affected by your injuries :_____
_____
_____.

FAMILY HISTORY:

Mother is alive/ deceased. Father is alive/ deceased.
I have _____#sister(s) and _____#brother(s).

Patient Name :_____

There is a Family History of:
____Cancer : type_____, _____Diabetes, _____High Blood Pressure,
_____Back Problems, _____Heart Disease, _____Emphysema/Lung problems,
_____Arthritis-(rheumatoid/ other), _____Kidney/Urinary Problems,
Other Problems
:_____.
_____There is no significant family health history.
****

SOCIAL HISTORY: Do You Smoke: Yes / No. ** Do You Drink Alcohol : Yes / No. **
Do You Drink Coffee : Yes / No.
****

MEDICATIONS : Please List Any Medications You Are Currently Taking , Dosage Per Day , And What the Medication is For : _____.
_____. _____.
_____. _____.
For additional space please use back of page.
****

PAST MEDICAL HISTORY :

Motor Vehicle Accidents:
Date accident :_____. * Were you injured: Y / N. * If yes where:_____.
Did you receive Medical care : Y / N. Chiropractic care : Y / N.

Date accident : _____. * Were you injured: Y / N. * If yes where: _____.
Did you receive Medical care : Y / N. Chiropractic care : Y / N.

Date accident : _____. * Were you injured: Y / N. * If yes where: _____.
Did you receive medical care : Y / N. * Chiropractic Care : Y / N
****

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Patient Name :_____.

Have you been given a <u>Permanent Impairment</u> or <u>Disability Rating</u> for any injury : Y / N.
If yes then list to what area and what degree of impairment/disability_____
_____.
****

<u>Have You Suffered "On The Job Injuries" :</u> Y / N.
If yes please give employer name , Date of Injury , And what area was injured:(If more than one injury please list in order of occurrence and whether you received chiropractic care or medical care : _____
_____
_____
_____
_____.
****

<u>Previous Surgeries :</u> Y / N
Please List Dates and Type/Area:

_____. _____.
_____. _____.
_____. _____.
_____. _____.
****

<u>Fractures / Broken Bones :</u> Y / N.
If yes give the Areas and Dates: _____.
_____. _____.
_____. _____.
****

YOUR HEIGHT IS :_____ YOUR WEIGHT IS : _____ YOUR AGE _____
ARE YOU _____RIGHT HANDED _____LEFT HANDED

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Patient Name :_____

Please circle any of the following conditions and / or illnesses if you have suffered from them in the past or are currently experiencing.

APPENDICITIS	ANEMIA	HEART DISEASE	ARTHRITIC PROBLEMS
PNEUMONIA	MEASLES	GOITER	EPILEPSY
MUMPS	FLU	POLIO	CHICKENPOX
PLEURISY	TUBERCULOSIS	DIABETES	DIVERTICULITIS
CANCER	BRONCHITIS	DIZZINESS	NERVOUSNESS
CHEST PAIN	LOSS OF SLEEP	FATIGUE	WHOOPING COUGH
FAINTING	MIGRAINES	CHEST PAIN	NUMBNESS / TINGLING
ASTHMA	ALLERGIES	EAR ACHES	RINGING IN EARS
HAY FEVER	COLITUS	CONSTIPATION	INCONTINENCE
CROHN'S	NOSE BLEEDS	NAUSEA	EXTREMITY PAIN
BEDWETTING	PROSTATE	THYROID	HEMORRHOIDS
TONSILITIS	HEARTBURN	PAIN IN NECK	FREQUENT COLDS
HIP PROBLEM	WEAKNESS	JOINT PAIN	JOINT STIFFNESS
DIARRHEA	SINUSITIS	GALLBLADDER	STOMACH ACHES
O.A.B.	ECZEMA	HIATAL HERNIA	KIDNEY INFECTION

*****************FOR WOMEN ONLY *****************

MENSTRUAL CRAMPS	PMS	EXCESSIVE FLOW	BACKACHE
PAINFUL PERIODS	CRAMPS	HOT FLASHES	IRREGULAR CYCLE