Welcome To Whiplash Pain Center

Confidential Patient Information Sheet

Date: _____

Patient's Name: _____

Address:_____City:_____State:_____Zip: _____

Date of Birth:_____/____/_____Age:_____Social Security Number:_____-____-_____

Cell/Text Number: (___)_____Work Phone Number: (____) _____

E-mail address: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow(er)

Spouse: Name: _____

Children: 1. Name _____ Age: _____
2. Name _____ Age: _____

Name of Employer: _____ Occupation: _____

Have You Been to A Previous Chiropractor? ☐ Yes or ☐ No
Name of Chiropractor _____ City: _____
Name of Chiropractor _____ City: _____

Do you prefer to pay by: ____Cash ____Check ____Credit Card

Do you have Health Insurance? ☐ Yes or ☐ No
If **YES**, please give your insurance card to the receptionist so that she may make a photocopy and confirm your level of coverage for spinal rehabilitation.

Payment Policies

1. **PAYMENT FOR YOUR FIRST DAY'S SERVICES IS DUE AT THE COMPLETION OF YOUR OFFICE VISIT.**
2. At the completion of your first visit, you will be advised as to the time you can return for your second consultation when the doctor will inform you of your examination results and whether or not your case has been accepted. You will be advised concerning recommendations, financial arrangements, and insurance coverage as appropriate.

Whiplash Pain Center

Name: _____ Date: _____

1. What is the purpose of this appointment (major complaint – please circle)?
   Headache ☐ Low–Back Pain ☐ Neck-Pain ☐ Mid-Back Pain ☐ Arm Pain ☐ Leg Pain ☐

   Other: _____

2. What is this condition due to (please circle)?
   Overexertion Strenuous Position ☐ Auto Accident ☐ Fall/Trip/Slip ☐

   Other: _____

3. When did this problem first occur (please be specific)? _____

4. Is this condition getting better, staying the same, or getting worse? _____

5. Has this condition been treated in the past? Yes ☐ or No ☐

6. List other doctors who have treated this condition: _____

7. On a scale of 1 to 10 (10 bedridden pain / 0 = feeling fine) how bad does this condition make you feel?
   _____

8. How does the pain feel?
   Dull Ache ☐ Sharp & Stabbing ☐ Burning ☐ Throbbing ☐

   Other: _____

9. Do you have pain, tingling, or numbness into either your arms or legs? _____

10. Have you noticed an irregular bowl or bladder patterns? _____

11. What relieves your condition? _____

12. What aggravates your condition? _____

13. Does this condition interfere with your: Work ☐ Sleep ☐ Daily Routine ☐

    Other: _____

14. What type of service do you desire? (please circle appropriate response)

    Temporary Relief ☐ Permanent Correction (if possible) ☐ Maintenance Care ☐

15. List any serious illnesses: _____

16. Are you pregnant? Yes ☐ or No ☐

17. List any surgical operations and dates:

_____

_____

Symptoms

Patient_____Date_____Date of Injury _____

Please fill in all symptoms you currently have <u>that you did not have</u> before the accident.

Orthopedic & Musculoskeletal Symptoms

- ☐ "Clunk" sound with neck movements
- ☐ Neck pain
- ☐ Upper back pain
- ☐ Low back pain
- ☐ Shoulder pain ☐ Left ☐ Right
- ☐ Upper arm pain ☐ Left ☐ Right
- ☐ Elbow pain ☐ Left ☐ Right
- ☐ Forearm pain ☐ Left ☐ Right
- ☐ Wrist pain ☐ Left ☐ Right
- ☐ Hand pain ☐ Left ☐ Right
- ☐ Hip pain ☐ Left ☐ Right
- ☐ Upper leg pain ☐ Left ☐ Right
- ☐ Knee pain ☐ Left ☐ Right
- ☐ Lower leg pain ☐ Left ☐ Right
- ☐ Ankle pain ☐ Left ☐ Right
- ☐ Foot pain ☐ Left ☐ Right
- ☐ Jaw pain
- ☐ Clicking in Jaw
- ☐ Pain when chewing
- ☐ Face pain
- ☐ Chest pain
- ☐ Stomach pain
- ☐ Bruise to _____
- ☐ Scrape/Cut to _____
- ☐ Other Symptom _____
- ☐ Other Symptom _____

Neurological Symptoms

- ☐ Numb/Tingling Arm / Hand L R
- ☐ Numb/Tingling Leg / Foot L R
- ☐ Weakness Arm / Hand L R
- ☐ Weakness Leg / Foot L R

Symptoms Associated with Injuries

- ☐ Stiffness or limited movement in joint(s)
- ☐ Headaches
- ☐ Muscle spasms/sore muscles
- ☐ Dizziness, lightheaded, woozy feeling
- ☐ Visual disturbances or vision change
- ☐ Sleep changes/disruption of patterns
- ☐ Pain radiates from one place to another
- ☐ Anxiety or nervous when driving
- ☐ Irregular Heartbeat or uneven pulse
- ☐ Feeling depressed about things
- ☐ I am taking the following medications ____

_____

_____

Brain/Neuropsych/MTBI/PTSD Symptoms

- ☐ I prefer being alone now (not socializing)
- ☐ I am sleepy, tired during day or doze off easily
- ☐ Upset stomach, nausea, heartburn or vomiting
- ☐ Difficulty concentrating, mind wanders easily
- ☐ I get overwhelmed easily
- ☐ Mood swings, happy one moment then sad
- ☐ Agitation (can't sit still, need to move around)
- ☐ Sadness, tearful episodes, crying easily
- ☐ Blurry vision, had to get or change glasses
- ☐ Asking people to repeat things or hearing problem
- ☐ I make wrong turns driving or can't remember time
- ☐ I get confused easily or cannot multi-task anymore
- ☐ I have difficulty finding some words when talking
- ☐ Bright lights bother me
- ☐ I cannot pay attention as long as before
- ☐ I am eating more or less than normal
- ☐ Room spins, lightheaded or woozy feeling
- ☐ Balance problems
- ☐ I feel like my head is "Foggy"
- ☐ I have forgotten computer passwords or ATM PIN
- ☐ I have to re-read things to understand what I read
- ☐ My thinking is slowed down
- ☐ Difficulty with adding/subtracting numbers
- ☐ Fear I will never be the same again
- ☐ Difficulty learning new things
- ☐ Difficulty understanding what people say to me
- ☐ Difficulty remembering or memory problems
- ☐ Cannot take on any more responsibility
- ☐ I can't make decisions as quickly as before
- ☐ Loss of libido or lack of sexual desire
- ☐ I do not feel as confident of my abilities
- ☐ I get panic attacks, fast heartbeat, nervous
- ☐ I am more irritable than usual
- ☐ Some food or drink tastes "Funny" to me now
- ☐ I get frustrated very easily
- ☐ Difficulty planning my life or organizing my work
- ☐ Flashbacks or frightening thoughts about accident
- ☐ I have had bad dreams about the accident
- ☐ I avoid places & objects that remind me about it
- ☐ I feel emotionally numb-no interest in my hobbies
- ☐ I'm feeling strong guilt, worry or depression
- ☐ I am having trouble remembering the accident
- ☐ I am easily startled since the accident - "jumpy"
- ☐ I feel tense or "on edge" most of the time
- ☐ I am having difficulty sleeping
- ☐ I get angry easily or even yell at people now

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ASSIGNMENT & RELEASE

1. I authorize the release of information to my family physician and employer.
2. I authorize the release of information to insurance companies.
3. I authorize the performance of photographs and x-rays to be used for treatment purposes.
4. I authorize Whiplash Pain Center (WPC) to be able to obtain records from other healthcare providers to assist in my care.
5. I authorize the performance of other diagnostic and therapeutic procedures and treatment.
6. I give WPC permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my health information during the course of care. Should I need to talk to the doctor at any time in private, the doctor will provide a room for these conversations.
7. It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, strains, and sprains.
8. I give permission to WPC to use my address, phone number and email to contact me if needed.
9. I authorize my insurance benefits to be paid directly to:

Whiplash Pain Center
714 St. Andrews Blvd.
Charleston, SC 29407
(843) 573-9333

I ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. I ALSO UNDERSTAND THAT IF I TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED TO ME WILL BE ***IMMEDIATELY DUE AND PAYABLE***.

Patient/Guardian: _____ Date: _____