injury clinic OF DALLAS AND PLANO

PERSONAL INFORMATION

NAME: _____ DATE OF BIRTH: _____ DATE OF INJURY: _____

ADDRESS:_____ CITY: _____ ZIP CODE: _____

CELL/HOME PHONE: _____ EMAIL: _____

EMERGENCY CONTACT.: _____ PHONE: _____

INSURANCE/ATTORNEY INFORMATION

YOUR AUTO INSURANCE CO.: _____

POLICY #: _____ CLAIM #: _____

NAME OF ADJUSTER AND PHONE #: _____

3RD PARTY INSURANCE CO.: _____

POLICY #: _____ CLAIM #: _____

NAME OF ADJUSTER AND PHONE #: _____

HAVE YOU RETAINED AN ATTORNEY? ☐ YES ☐ NO IF YES, NAME OF ATTORNEY: _____

EMPLOYMENT

NAME/ADDRESS: _____

ACCIDENT & MEDICAL CARE INFORMATION

WAS POLICE NOTIFIED? ☐ YES ☐ NO

YOU WERE STRUCK FROM ☐ BEHIND ☐ FRONT ☐ LEFT SIDE ☐ RIGHT SIDE

YOU WERE ☐ DRIVER ☐ PASSENGER ☐ FRONT SEAT ☐ BACK SEAT

WHICH HOSPITAL WERE YOU TAKEN TO? _____

DID YOU SEEK OTHER MEDICAL CARE? ☐ YES ☐ NO IF YES, DOCTOR'S NAME & NUMBER: _____

PATIENT SIGNATURE: _____ DATE: _____

Patient Case History

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you.
We want your visit with us to be comfortable, helpful, and educational.

confidential health information

1 PATIENT INFORMATION

clinic id | date

last name | first name | m.i.

2 HEALTH COMPLAINTS

Are you here because you were injured while working, in a motor vehicle collision, or in another accident? ☐ yes ☐ no

What services interest you? (mark all that apply)

- ☐ injury prevention
- ☐ balance and coordination training
- ☐ range of motion, mobility, or flexibility therapy
- ☐ treatment for pain
- ☐ spinal and body alignment
- ☐ strengthening and stamina exercise
- ☐ patient education classes
- ☐ body composition counseling
- ☐ nutritional and supplement counseling
- ☐ other: _____

What is your **primary** complaint?

How long have you been experiencing this **primary** complaint?

How does the **primary** complaint feel? ☐ dull/achy ☐ sharp ☐ numb ☐ tingling ☐ burning ☐ cold

How often do you experience the **primary** complaint? ☐ constantly ☐ daily ☐ weekly ☐ monthly ☐ yearly

Using the scale below, rate how your **primary** complaint affects your life. (mark only one box below)

1	2	3	4	5	6	7	8	9	10
no pain or discomfort	slight discomfort	pain that does not affect my activity	pain that affects my daily activities	pain that prevents performing my daily activities	pain that limits my work schedule	pain that prevents working at all	pain that prevents working and all personal activity	pain that keeps me bed ridden	pain that causes thoughts of suicide

If you have missed work because of your **primary** complaint, what was your last day of work?

What do you believe is causing your **primary** complaint?

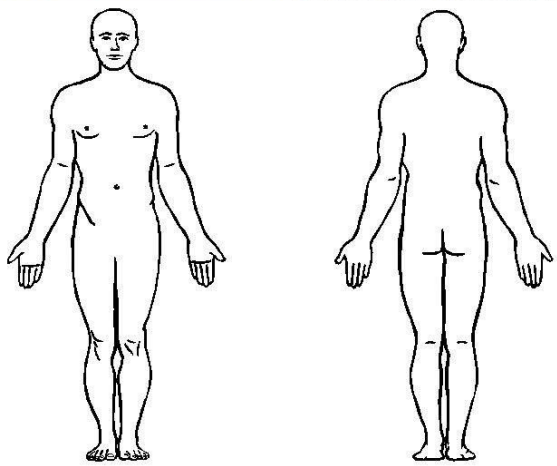
List other health complaints (2-5) on the following lines.

2 _____ 4 _____

3 _____ 5 _____

Do you have any other condition other than what brings you here? ☐ yes ☐ no
If YES, list it here:

Please mark the areas of all of your complaints on the diagrams to the right. Include any descriptors or comments, concerning your health complaints that were not mentioned above.



3 LIFESTYLES & HABITS

patient name

How many hours of television do you watch a day? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ >5

Do you usually snack while watching television? ☐ yes ☐ no

How many hours per day do you use a computer at work or home? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ >5

How many hours per day do you ride in a car or other vehicle? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ >5

How often do you exercise? ☐ daily ☐ 3x's/week ☐ 2x's/week ☐ 1x/week ☐ I don't exercise

How long do your exercise work outs last? ☐ >1 hour ☐ 1 hour ☐ 30 minutes ☐ < 30 minutes ☐ NA

What are your exercise activities? (mark all that apply) ☐ I don't exercise

☐ walking ☐ swimming ☐ weight lifting

☐ stretching/flexibility ☐ yoga/Pilates ☐ resistance bands

☐ running/treadmill/rowing/climbing ☐ group exercise classes ☐ other_____

Do you take a multi-vitamin? ☐ yes ☐ no If YES, what brand do you take?

List any other nutritional supplements you are currently taking.

supplement	reason	supplement	reason
1.		3.	
2.		4.	

How often do you use tobacco? ☐ never ☐ daily ☐ weekly ☐ monthly ☐ yearly

How many servings of alcohol do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

How many servings of coffee do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

How many servings of soda do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

4 FAMILY HISTORY

Mark the following conditions as they pertain to your immediate family. n=never p=previously c=currently

diabetes	n p c mother	n p c father	n p c brother	n p c sister
heart problems	n p c mother	n p c father	n p c brother	n p c sister
kidney problems	n p c mother	n p c father	n p c brother	n p c sister
cancer	n p c mother	n p c father	n p c brother	n p c sister
headaches	n p c mother	n p c father	n p c brother	n p c sister
back pain	n p c mother	n p c father	n p c brother	n p c sister
obesity	n p c mother	n p c father	n p c brother	n p c sister
poor conditioning	n p c mother	n p c father	n p c brother	n p c sister

5 CONDITIONS

Mark the following conditions as they currently pertain to you.

alcoholism	☐ yes ☐ no	epilepsy	☐ yes ☐ no	low back pain	☐ yes ☐ no	polio	☐ yes ☐ no
anemia	☐ yes ☐ no	goiter	☐ yes ☐ no	measles	☐ yes ☐ no	rheumatic fever	☐ yes ☐ no
appendicitis	☐ yes ☐ no	heart disease	☐ yes ☐ no	mental disorder	☐ yes ☐ no	tuberculosis	☐ yes ☐ no
arthritis	☐ yes ☐ no	HIV positive	☐ yes ☐ no	mumps	☐ yes ☐ no	venereal infection	☐ yes ☐ no
cancer	☐ yes ☐ no	influenza	☐ yes ☐ no	pleurisy	☐ yes ☐ no	whiplash	☐ yes ☐ no
				pneumonia	☐ yes ☐ no	whooping cough	☐ yes ☐ no

6 INJURIES

patient name

List any auto collisions that you were involved in, either as the driver or passenger, below. Begin with the most recent.

type of collision	type of treatment received	date of collision
1.		
2.		
3.		

List any job injuries that you experienced below. Begin with the most recent.

type of job injury	type of treatment received	date of job injury
1.		
2.		
3.		

List any sports injuries that you experienced below. Begin with the most recent.

type of sports injury	type of treatment received	date of sports injury
1.		
2.		
3.		

List any other injuries caused by falls or impacts. Begin with the most recent.

type of injury	type of treatment received	date of injury
1.		
2.		
3.		

7 HOSPITAL / MEDICINE

Have you had breast implant surgery? ☐ yes ☐ no

Have you had knee or hip replacement surgery? ☐ yes ☐ no

Do you have a pacemaker? ☐ yes ☐ no

Do you have any other implantable medical devices in your body? ☐ yes ☐ no

Mark all of the following procedures as they pertain to you.

vaccinations	☐ yes	☐ no	tubes in ears	☐ yes	☐ no	rectal surgery	☐ yes	☐ no
tonsillectomy	☐ yes	☐ no	appendectomy	☐ yes	☐ no	sinus surgery	☐ yes	☐ no
gall bladder removal	☐ yes	☐ no	female/male surgery	☐ yes	☐ no	hernia surgery	☐ yes	☐ no
back surgery	☐ yes	☐ no	_____			thyroid surgery	☐ yes	☐ no
						stomach surgery	☐ yes	☐ no

List any prescription or over-the-counter medications you are currently taking.

medication	reason	medication	reason
1.		3.	
2.		4.	

Have you ever had a lapse of memory? ☐ yes ☐ no Were you ever knocked unconscious? ☐ yes ☐ no

List any broken bones or dislocations that you had.

Have you ever had a spinal tap or spinal injection? ☐ yes ☐ no

8 SYSTEM REVIEW

patient name

Mark the following conditions that are **currently** a cause of significant concern for you.

General

☐	consistent fainting	☐	chills	☐	convulsions	☐	depression	☐	dizziness
☐	loss of weight	☐	fatigue	☐	fever	☐	headache	☐	loss of sleep
☐	weight gain	☐	neuralgia	☐	night sweats	☐	wheezing	☐	nervousness

Gastro-Intestinal

☐	constipation	☐	diarrhea	☐	gall bladder problems	☐	hemorrhoids	☐	jaundice
☐	liver problems	☐	nausea	☐	stomach pain	☐	poor appetite	☐	poor digestion
☐	rectal bleeding	☐	vomiting	☐	vomiting blood				

Eye/Ear/Nose/Throat

☐	asthma	☐	crossed eyes	☐	deafness	☐	earache	☐	ear discharge
☐	ear noises	☐	enlarged thyroid	☐	frequent colds	☐	hay fever	☐	hoarseness
☐	nasal obstruction	☐	nose bleeds	☐	pain in eyes	☐	poor vision	☐	sinusitis
☐	sore throat	☐	tonsillitis						

Respiratory

☐	chest pain	☐	chronic cough	☐	difficulty breathing	☐	spitting blood	☐	spitting phlegm

Muscles/Joints/Bones

☐	backache	☐	foot problems	☐	pain bet. shoulders	☐	painful tailbone	☐	stiff neck
☐	spinal curvature	☐	swollen joints	☐	tremors	☐	twitching	☐	weakness

Cardio-Vascular

☐	ankle swelling	☐	high blood pressure	☐	low blood pressure	☐	heart trouble	☐	pain over heart
☐	poor circulation	☐	rapid heart	☐	slow heart	☐	strokes		

Skin or Allergies

☐	bruise easily	☐	dryness	☐	eczema	☐	hives	☐	itching
☐	sensitive skin								

Women

☐	cramps	☐	excessive flow	☐	hot flashes	☐	irregular cycle	☐	painful periods

9 PREGNANCY — WOMEN ONLY

X-rays are contra-indicated during pregnancy. This clinic does not knowingly x-ray women who are or may be pregnant regardless of stage or trimester of pregnancy. If there is a chance that you may be pregnant let the doctor or assistant know right now.

Are you pregnant? ☐ yes ☐ no

On what date did your last period begin?

Mark the following situations as they pertain to you.

tubal ligation	☐ yes ☐ no	complete or partial hysterectomy	☐ yes ☐ no	partner had a vasectomy	☐ yes ☐ no
less than 10 days since the start of my last period	☐ yes ☐ no	taking birth control pills	☐ yes ☐ no		

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes and I am requesting these services
- It is my responsibility to complete the clinic's forms accurately
- It is my responsibility to notify the doctor if any of my information has changed or requires updating
- Original x-rays are the clinic's property and copies of the original film(s) and report(s) will be released to me upon written request

patient or guardian signature

date

injury clinic
OF DALLAS AND PLANO

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustment and other chiropractic procedures, including various modes of physical therapy and diagnostic x-ray, on me or patient named below and/or other licensed doctors of chiropractic who now or in the future treat me. While employed by working or associate with or serving as a backup for the doctor of chiropractic named below including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that as in the practice of chiropractic there are some risks to treatment including, but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of procedure which the doctor feels at the time, based upon the fact then known, is in my best interest.

I have read or have had it read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my preset condition and for any future condition and any further condition(s) for which I seek.

Doctor of Chiropractic

Atousa Bahadori, D.C.

Print Patient Name: _____

Signature of Patient: _____

Date Signed: _____

Phone 469.782.1888 Fax 469.782.1889 www.injuryclinicdallas.com 4601 Old Shepard Pl Ste 405 Plano, TX 75093

Phone 972.644.5555 Fax 972.744.0078 www.injuryclinicdallas.com 905 Custer Road, Richardson, TX 75080

injury clinic
OF DALLAS AND PLANO

Authorization for Release of Records

TO:_____

PATIENT NAME:_____

SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH:_____

SIGNATURE OF PATIENT/PARENT/GUARDIAN: _____

I authorize you, your agent or legal representative to release and disclose as requested all that medical information, including but not limited to records pertaining to examination, treatment, consultation, billing records, x-ray, CTs, MRIs and report, history, laboratory findings, admissions and discharge report, treatment records, diagnosis and prognosis records, nurse and doctor's notes, and any other non-medical information in my file.

Sincerely,

Atousa Bahadori, DC

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