McCormick Chiropractic - 92 Kemp Road - Pottstown, PA 19465
Phone: 610-705-0201

PERSONAL INFORMATION

Today's Date _____

Name_____ Home Phone_____

Work/Cell Phone _____

Address_____

Email_____

Social Security #_____

Date of Birth_____

Sex Male Female Height ____' ____" Weight _____ lbs

Occupation _____ Marital Status_____

Employer_____ No of Children_____

Address_____

If minor, the name of parent or guardian_____

Whom should we contact in case of an emergency?_____

Relation _____ Phone_____

Address_____

How did you hear about our office?_____

Have you ever been to a chiropractor before? YES NO If so, whom?_____

ATTORNEY or ADVOCATE INFORMATION: if applicable

Name _____

Phone _____

Address _____ City _____

State _____ Zip _____

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NATURE OF ACCIDENT

1. Date of Accident _____ Time of Day _____ Weather Conditions _____
2. Were you: ( ) Driver or Passenger in the ( ) Front Seat ( ) Back Seat
3. Do you have head rests? ( ) No ( ) Yes Were you wearing a seat belt? ( ) No ( ) Yes
4. What direction were you headed? ( ) North ( ) South ( ) East ( ) West on (name of street) _____
Cross Street if applicable? _____ In what City/State? _____
5. What direction was the other vehicle headed? ( ) North ( ) South ( ) East ( ) West on (name of street)
_____
6. From which direction were you struck? ( ) Behind ( ) Front ( ) Left side ( ) Right side
7. Approximate speed of your car was _____ mph; And the other car _____ mph.
8. Were you knocked unconscious? ( ) No ( ) Yes (If yes, for how long): _____
9. Were police notified? ( ) No ( ) Yes If yes, was a report taken? ( ) No ( ) Yes
10. In your own words, please describe the accident. _____
_____
_____
11. The Weather Conditions were they: Sunny Raining Snowing Foggy
12. The Road was: Dry Wet Icy Time of Day: Dawn Day Dusk Night
13. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) No ( ) Yes (If yes, please describe in detail): _____
_____
14. Please describe how you felt emotionally and physically (did symptoms get worse?):
a. DURING the accident: _____
b. IMMEDIATELY AFTER the accident: _____
c. LATER THAT DAY: _____
d. THE NEXT DAY: _____
15. Have you been treated by another doctor, other than this chiropractic office, since this accident?
( ) No ( ) Yes (If yes, Dr.'s name & address): _____
What type of treatment did you receive? _____
16. Since this injury occurred, are your overall symptoms: ( ) Improving ( ) Getting Worse ( ) Staying the Same

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17. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:
( )Headache ( )Irritability ( )Numbness in Toes ( )Face Flushed ( )Feet Cold
( )Neck Pain ( )Chest Pain ( )Shortness of Breath ( )Buzzing in Ears ( )Hands Cold
( )Neck Stiff ( )Dizziness ( )Fatigue ( )Loss of Balance ( )Ears Ring
( )Sleep Problems ( )Head feels Heavy ( )Depression ( )Fainting ( )Constipation
( )Back Pain ( )Pins & Needles in Arms ( )Lights Bother Eyes ( )Loss of Smell ( )Cold Sweats
( )Nervousness ( )Pins & Needles in Legs ( )Loss of Memory ( )Loss of Taste ( )Fever
( )Tension ( )Numbness in Fingers ( )Upset Stomach ( )Diarrhea ( )Arm Pain

Symptoms other than above _____

SYMPTOMATOLOGY: (Pain characteristics for major area of complaint)

The pain started: _____
_____

The pain is made better by: _____
_____

and worse by_____
_____

There is / There isn't radiation into: _____
_____

There is / There isn't parentheses (tingling/numbness) into: _____
_____

The pain is located: _____
_____

The pain is (as far as timing is concerned: i.e. comes & goes, constant, etc.):_____
_____

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DAILY ACTIVITIES:

How many days out of an average week do you have pain? >1 2-5 5-7
How much time out of an average day are you in pain? Always Sometimes Never
What are the worst times of day for the pain? Morning Noon Evening Other
When do you feel the best? Morning Noon Evening Other
How many hours are in your normal workday?_____
Please indicate your daily job duties and any activities that you are occasionally asked to perform:
STANDING OPERATING EQUIPMENT DRIVING SITTING TWISTING WORK W/ARMS ABOVE HEAD
WALKING CRAWLING TYPING LIFTING BENDING STOOPING
What positions can you work in with minimum physical effort, and for how long?
Do you work with others who can help you with any heavy lifting? YES NO
While in recovery, are there any light-duty tasks you could request? YES NO

HEALTH HISTORY

Have you ever had any of the following diseases or conditions?
HEART ATTACK or STROKE HEART SURGERY or PACEMAKER HEART MURMUR
CONGENITAL HEART DEFECT MITRAL VALVE COLLAPSE ARTIFICIAL VALVES
ALCOHOL/DRUG ABUSE VENEREAL DISEASE HEPATITIS HIV+/AIDS SHINGLES CANCER
FREQUENT NECK PAIN EMPHYSEMA ANEMIA HIGH/LOW BLOOD PRESSURE
PSYCHIATRIC PROBLEMS RHEUMATIC FEVER SEVERE/FREQ. HEADACHES
KIDNEY PROBLEMS ULCERS/COLONITIS FAINTING/SEIZURE/EPILEPSY SINUS PROBLEMS
ASTHMA DIABETES DIFFICULTY BREATHING TUBERCULOSIS
LOWER BACK PROBLEMS ARTIFICIAL BONES/JOINTS ARTHRITIS

Please list any other medical conditions that you have or have ever had. _____
Please list any allergies. _____
Please list previous surgeries and dates.
_____
Please list any past motor vehicle accidents or traumas and dates._____
Is there anything else about your health history or family health history that you feel is important to share
_____

Patient/Legal Guardian Signature_____ Date_____