## Application for Treatment

General Information	Current Medical History
Name :	Any Current health problems
Address :	
City/Zip :	
Home phone # :	Any Current medications
Social Security # :	
Birth date :	
Occupation :	Are you pregnant?
Employer :	Yes No
Work phone # :	
Spouse :	
Spouse's employer :	General Injury History
Spouse's work # :	
Emergency contact :	
Today's date :	Was this crash on the job?  Yes No
Date of injury :	You were: Driver Front passenger Rear passenger Other
	Vehicle driven by:
	Your vehicle(yr,make,model):
	Estimated speed at moment of crash:
Past Medical History	Stopped Slowing Accelerating
Surgeries and dates:	Other vehicle(yr,make,model):
	Time of day:
	Road conditions: Dry Damp Wet Snow lce ther
Fractures and dates:	Seatbelt: Wearing Not wearing
	Did the airbag deploy: Yes No NA
	Where were you looking on impact:
Serious illnesses and dates:	traight ahead Down Right Left
	Combination of two
	Braced for impact: Yes No
Other injuries:	Hands: One on wheel Two on wheel
	Brakes applied: Yes No
	In your own words, describe what happened
Any history of current complaints and dates:	
Prior chiropractic treatment and dates:	
	Were you aware that the crash was about to take place: Yes No

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Crash diagram:
During the crash
Did any of your body strike any parts of the vehicle:  Yes  No
If yes, what part of your body stuck what part of the car:
Wearing hat or glasses: Yes No  If yes, still on after crash: Yes No
Did you lose consciousness: Yes No  Was the police called Yes No  Was areport made: Yes No
Hospital visit
Xrays taken: Yes No  If yes, what body part:
Diagnosis:
Lab work:  Yes No
Braces or supports: