ELANCO CHIROPRACTIC, INC.
1907 Division Highway • Ephrata, PA 17522
Office: 717-355-5000 • Fax: 717-354-8587
www.elancochiropractic.com

Building Healthy Living

Confidential Case History: Auto Accident Related

Today's Date: ______________

First Name: ______________________________ **MI.**______ **Last Name:** ___________________________________

Home Address: ____**City:** ______________ **State:** _____ **Zip:**______

Home Phone: ________-_________-___________ **Cell phone:** _______ - __________ - _______________

Male/Female **Date of Birth** ________/_________/_____________ **Age:** ____________

Email: ____________________________________

Marital Status: S / M / D / W **No. of Children:** ________ **Occupation:** __________________________________

Employer: ____________________ ________________ ____

Work Phone: ________-________-_________ **Employed: Work Full /Part Time, Student Full/Part Time**

Spouse: _________________________ **Spouse Occupation:** _______________ **Cell phone:** _____-_____-________

In addition to your spouse, whom should we contact in case of an emergency?

Name: ____ **Relationship:** ________________________________

Phone: _______-_________-___________ **Address:**____

MAJOR MEDICAL INSURANCE:
Insurance Company Name: ____

Address: ____

City: ____ **State:** ________ **Zip Code:** _____________________

Policy #: __________________________________ **Group #:** _____________________________________

Phone: _________-_________-________________

Patient Name: ______________________________ Date: ____________

How did you hear about our office?

Please check all that apply

- ☐ Doctor : Name? ____________________
- ☐ Presentation
- ☐ Expo : Name? ____________________
- ☐ Postcard/letter
- ☐ Newsletter
- ☐ Newspaper
- ☐ Hometown Values Mag.
- ☐ Phonebook
- ☐ Internet Search
- ☐ ELANCO Website
- ☐ Facebook
- ☐ Staff : Name? ____________________
- ☐ Patient : Name? ____________________
- ☐ Care Enough to Share Card

AUTO INSURANCE

Insurance Company Name: ____

Address: ____

City: _______________________________________ State: _______ Zip Code: _________________

Policy #: ______________________________ Group #: ________________________________

Phone: ________-________-______________

INSURED: **Check if same as above: ____**

First Name:_________________________ MI._____ Last Name: ____________________________

Male / Female DOB: _____/_____/______

Address: ____

City: ______________________________ State: _________ Zip Code: _______________________

Phone: ________-_________-______________ Employer: ___________________________________

ATTORNEY:

Name: ____

Address: ____City: ____________________

State______ Zip Code: _________ Phone Number__________-_____________-_____________________

Date of Accident: _____/______/_______ Time of Accident: ____:____AM/PM

Did you receive a copy of police report? _______________

Have you been under Chiropractic care before? Yes / No

If yes please describe: ____

Doctor's Name: ___________________________ Date of Last Treatment: _______/_______/_______

Name of Practice: ____

Practice Phone: _________-__________-______________

Please put the appropriate symbol **(X)** or **(O)** on the line for any of the following symptoms
NOW have **(X)** OR **HAD** previously **(O)**

___Neck Pain
___Neck Stiffness
___Neck Grating
___Neck Tension
___Mid-back Pain
___Mid-back Stiffness
___Mid-back Grating
___Mid-back Tension
___Low back Pain
___Low back Stiffness
___Low back Grating
___Low back Tension

Pain in:
___Shoulders
___Arms
___Hands
___Hips
___Legs
___Feet

Numbness in:
___Shoulders
___Arms
___Hands
___Hips
___Legs
___Feet

Other Conditions:
____
____
____
____

Do you have any heart conditions?
YES / NO Explain:
____
____
____
____

Do you any have lung conditions?
YES / NO:
Explain:_____________

___Painful Tailbone
___Sciatica
___Painful Joints
___Swollen Joints
___Bursitis
___Hernia
___Pinched Nerves
___Headaches
___Migraines
___Dizziness
___Fainting
___Fatigue
___Anxiety
___Depression
___Bad moods and Behavior
___Tremors
___Insomnia
___Sweats
___Chills
___Belching
___Excessive Gas
___Colon Trouble
___Constipation
___Diarrhea
___Indigestion
___Hemorrhoids
___Nausea
___Gall Bladder Trouble
___Liver Trouble
___Vomiting
___Stomachaches
___Asthma
___Allergies
___Sinus Problems
___Tonsillitis
___Eye Pain
___Ringing in the Ears
___High Blood Pressure
___Low Blood Pressure
___Chest Pains
___ Poor Circulation

___Chronic Cough
___Difficulty Breathing
___Bedwetting
___Blood in Urine
___Frequent Urination
___Painful Urination
___Kidney trouble
___Prostate Trouble
___Menstrual Cramps
___Excessive Flow
___Irregular Cycle
___Pregnancy
___Menopausal Symptoms
___Lumps in Breast

Conditions:
___Alcoholism
___Anemia
___Arteriosclerosis
___Arthritis
___Cancer,
Type:________________
____
____
___Diabetes
___Drug Abuse
___Epilepsy
___Heart Disease
___Miscarriage
___Polio
___Stroke
___T.B.
___Ulcers
___Mental Disorders
___Moles (color and/or size change)
____
____

Other: ______________________
____
____
____
____

Current Medications (If possible please provide list): ______________________________
____

Surgeries and Dates: ____

____

Serious Ilnesses and Dates: ____

Fractures and Dates: ____

Worker's Compensation Injuries and Dates: ____

____

Auto Accidents, Dates, Injuries and Treatment: ____

____

Sports or Other Injuries, Dates and Treatment: ____

____

FAMILY HISTORY

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					
Maternal Grandfather					
Maternal Grandmother					
Paternal Grandfather					
Paternal Grandmother					

Social History: Smoke: ( ) None Pack/Day ______ Years ________
Alcohol: ( ) Never ( ) Social ( ) Light ( ) Moderate

What is your **Height:** ________ **Weight:** _________ **Shoe size**: ________ **Dominant Hand:** Right / Left

History of Onset: ____

Please List Each Major Complaints: (ex: neck, back, shoulder, etc.)

1. ____
(rate your pain) Good- 0 1 2 3 4 5 6 7 8 9 10 -Bad

☐ **occasional** ☐ **intermittent** ☐ **frequent** ☐ **constant**

THIS COMPLAINT AFFECTS*:* (Circle all that apply)
Work, Sleep, Driving, Hobbies, Bending, Eating, Grooming, Family Life, Lifting (light-medium-heavy)

2. ____
(rate your pain) Good- 0 1 2 3 4 5 6 7 8 9 10 -Bad

☐ **occasional** ☐ **intermittent** ☐ **frequent** ☐ **constant**

THIS COMPLAINT AFFECTS*:* (Circle all that apply)
Work, Sleep, Driving, Hobbies, Bending, Eating, Grooming, Family Life, Lifting (light-medium-heavy)

3. ____
(rate your pain) Good- 0 1 2 3 4 5 6 7 8 9 10 -Bad

☐ **occasional** ☐ **intermittent** ☐ **frequent** ☐ **constant**

THIS COMPLAINT AFFECTS*:* (Circle all that apply)
Work, Sleep, Driving, Hobbies, Bending, Eating, Grooming, Family Life, Lifting (light-medium-heavy)

4. ____
(rate your pain) Good- 0 1 2 3 4 5 6 7 8 9 10 -Bad

☐ **occasional** ☐ **intermittent** ☐ **frequent** ☐ **constant**

THIS COMPLAINT AFFECTS*:* (Circle all that apply)
Work, Sleep, Driving, Hobbies, Bending, Eating, Grooming, Family Life, Lifting (light-medium-heavy)

Have you ever had the same or similar condition in the past:
3 Months - Yes / No 6 Months - Yes / No 1 Year - Yes / No

If yes please describe: ____

Is there anything you can do to relieve the problem? Yes / No
If yes please describe: ____

Have you been treated for any other health condition in the past year? Yes / No
If yes please describe: ____

Name of Primary Care Physician: ____

Primary Care Physician Phone: _______-________-__________

Hospital/Practice location: ____

WOMEN ONLY

Are you pregnant, or is there any possibility that you may be pregnant?

YES / NO

Signature: ____

Authorization and Release:

I authorize payment of insurance benefits directly to ELANCO Chiropractic and Rehabilitation Center, Inc and or the Owner/President of ELANCO Chiropractic Dr. Gary J. Greve. I understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, Healthcare operations and coordination of care. I understand that I am responsible for all cost of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctors, any fees for professional services rendered will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 18%.

Patient's/Guardians Signature_______________________________________DATE:____/____/______

Auto Accident Injury Information:

What was your position in the vehicle?

( ) The driver ( ) The rear passenger

( ) The front passenger ( ) A pedestrian ( ) Other: ________________________

What type of vehicle were you driving?

( ) Compact car ( ) Full size car ( ) Full size truck ( ) Motorcycle passenger

( ) Mid size car ( ) Compact truck ( ) Mini van ( ) Compact sport utility vehicle

( ) Motor home ( ) Bicycle ( ) Full size van ( ) Full size sport utility vehicle

( ) Motorcycle ( ) Other: ____

What speed were you traveling at the time of the accident?

( ) Stopped ( ) Traveling faster than 65 mph

( ) Slowing down at an intersection ( ) Moving slowly

( ) Traveling at approximately _____ mph ( ) Merging into traffic

( ) Other: ____

Who hit whom?

( ) Was struck by another vehicle ( ) Struck a stationary object

( ) Struck another vehicle ( ) Other: ____________________________________

What was your vehicle's point of impact?

( ) On the front right side ( ) On the front left side ( ) On the front

( ) On the right rear ( ) On the left rear ( ) On the rear

( ) On the right front ( ) On the left front ( ) On the middle front

( ) On the right side ( ) On the left side ( ) On the middle rear

( ) On the rear right side ( ) On the rear left side

( ) On the middle right side ( ) On the middle left side

( ) Other: ____

What speed was the other vehicle traveling?

( ) Stopped at a stop light ( ) Traveling faster than 65 mph

( ) Slowing down for an intersection ( ) Moving slowly

( ) Traveling at approximately _____ mph ( ) Merging into traffic ( ) Other: __________________________

What was the other vehicle's point of impact?

( ) On the front right side
( ) On the right rear
( ) On the right front
( ) On the right side
( ) On the rear right side
( ) On the middle right side
( ) On the front left side
( ) On the left rear
( ) On the left front
( ) On the left side
( ) On the rear left side
( ) On the middle left side
( ) On the front
( ) On the rear
( ) On the middle front
( ) On the middle rear
( ) Other: ______________________________

Were you wearing seat restraints?

( ) Was wearing a full lap and shoulder restraint
( ) Was wearing a lap restraint
( ) Was wearing a shoulder restraint
( ) Was not wearing any seat restraints
( ) Other: ______________________________

What position were your vehicles head rests in?

( ) Did have a head rest which was adjusted in the lowest position
( ) Did have a head rest which was adjusted in the middle position
( ) Did have a head rest which was adjusted in the highest position
( ) Was not equipped with a head rest
( ) Other: ______________________________

Did your air bag deploy?

( ) Air bags were deployed
( ) Air bags were not deployed
( ) Other:______________________________

If yes, were you struck by the air bag?

( ) Yes
( ) No

Were you prepared for the impact?

( ) Was completely surprised by the accident
( ) Saw the collision coming and braced appropriately
( ) Saw the collision coming
( ) Other: ______________________________

What position was your body in just prior to impact?

( ) A straight position
( ) A position rotated to the left
( ) A tilted forward position
( ) A position rotated to the right
( ) cannot be remembered
( ) Other: ____

What happened to your body the moment of impact?

( ) Body was tensed for impact
( ) Body violently torqued and twisted
( ) Body whipped violently forward and backward
( ) Body was thrown over the seat
( ) Body was thrown from the vehicle
( ) Body was thrown violently from side to side
( ) Body was pinned in the vehicle
( ) Body was badly cut and bruised
( ) Other: ____

After the crash I had:

( ) Headache
( ) Neck Pain
( ) Dizziness
( ) Nausea
( ) Confusion/disorientation
( ) Parethesia (s) / tingling /numbness
( ) Extremity Pain. If yes where? ____
( ) Back Pain
( ) **Other:** ____

When did symptoms first appear?

( ) Immediately, (describe which symptom) ____________________________________
( ) __________ hours afterward.

Did you receive medical attention at the scene of the accident?

( ) Did receive medical attention
( ) Did not receive medical attention
( ) Other (**Describe treatment**):____

____

Where did you go immediately following the accident?

( ) Was taken to the hospital ( ) Was taken to a personal physician

( ) Was taken home ( ) Was taken to this office

( ) Resumed activities

( ) Other: ____

Who was the vehicle's driver: _____________________________________

Your vehicle (year, make, model): ____

Other vehicle (year, make, model): ____________________________________

Light conditions:

( ) Day Light ( ) Dawn ( ) Dusk ( ) Dark

Road Conditions:

( ) Dry ( ) Damp ( ) Wet ( ) Snow ( ) Ice

( ) Other: ____

Was the seat adjustment altered by the accident?

( ) Yes ( ) No

Was the seat broken?

( ) Yes ( ) No

Were you wearing a hat or glasses?

( ) Yes ( ) No

If yes, still on after the crash?

( ) Yes ( ) No

Estimated property damage to your vehicle:

$: ____________________________

Estimated damage to other vehicle(s):

( ) None

( ) Minimal

( ) Moderate

( ) Major

List each of your body parts that struck the following vehicle during the accident.

Dashboard= D, Windshield= W, Steering Wheel=S, Right Door=RD, Left Door=LD, Seat Frame=SF

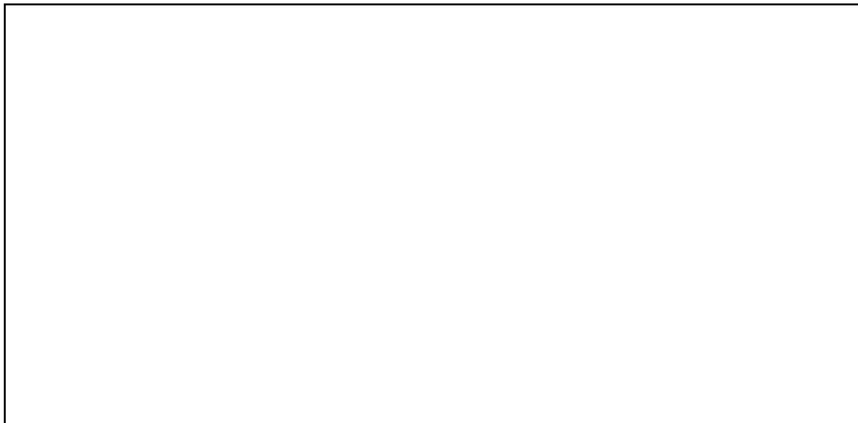
( ) Right side of the head	( ) Right arm	( ) Right wrist	( ) Right knee
( ) Right shoulder	( ) Right elbow	( ) Right hip	( ) Right ankle
( ) Left side of head	( ) Left arm	( ) Left wrist	( ) Left knee
( ) Left shoulder	( ) Left elbow	( ) Left hip	( ) Left ankle

( ) Other: Unknown Objects: ____

<u>Accident History and Diagram:</u>

Use 1-2-3, Your vehicle =1, Other vehicle =2, Object = 3

Draw what happened:



History of onset (Injury) Explain in your own words what happened at the time of the accident:

____

____

____

____

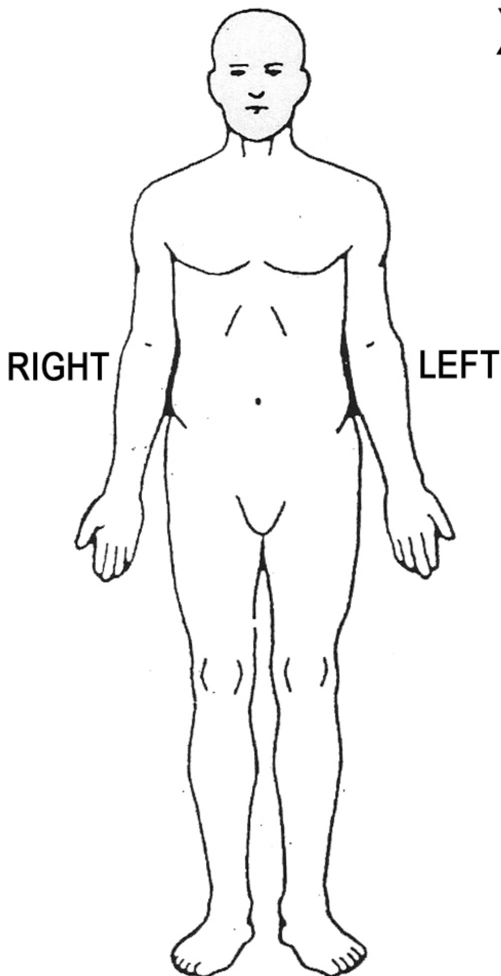
____

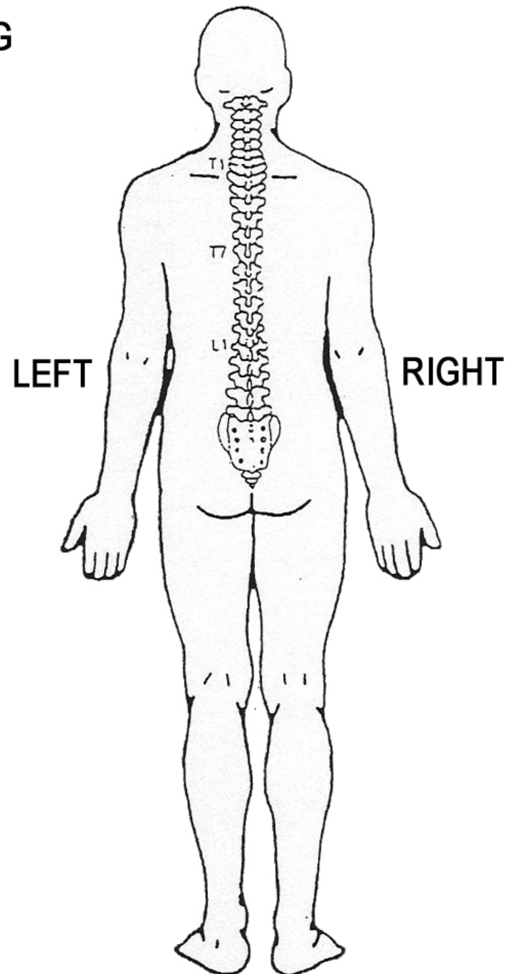
____

Pain Drawing

Use the appropriate symbols shown below to mark the areas on your body where you feel these described sensations. Include ALL areas affected by your pain, and mark the type and area.

- = PINS AND NEEDLES
- O NUMBNESS
- / STABBING
- X BURNING
- ʌ ACHING





Signature: ______________________________ Date: ______________________