Patient Name:______________ **Boutwell Chiropractic Group P.C.** Date: ________

Patient Name: ______________________________ Birthdate: ________________ Sex: M/F
Address: ________________________________ City: ____________ State: _____ Zip: _________
Telephone: ________________________ SSN: ______________________
Email: ________________________________ Referral: ________________________________
Marital Status: ___________________________ Spouse Name: ______________________________
Occupation: _____________________ Employer: _____________________ Work #: ____________
Address: ________________________________ City: ____________ State: _____ Zip: __________

Health Plan: __________________________ Subscriber: _________________________

ID#: ___________________ Group #: __________________

Primary Care Physician: ______________________________ PCP phone #: _____________________

Emergency Contact: ____
Relationship: ___________________________________ Phone #: __________________________

Health History:
Please check all the following that apply to you: None Apply

No	Yes	Condition
☐	☐	History of Recent Infection
☐	☐	Recent Fever
☐	☐	HIV/AIDS
☐	☐	Diabetes
☐	☐	Corticosteroid Use
☐	☐	Birth Control
☐	☐	High Blood Pressure
☐	☐	Stroke (date) _________
☐	☐	Dizziness/Fainting
☐	☐	Numbness in the Groin/Buttocks
☐	☐	Urinary Retention
☐	☐	Aortic Aneurysm
☐	☐	Cancer/Tumor
☐	☐	Osteoporosis
☐	☐	Recent Trauma
☐	☐	Autoimmune Disease

No	Yes	Condition
☐	☐	Prostate Problems
☐	☐	Frequent Urination
☐	☐	Pregnancy, # of births ________
☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Epilepsy/seizures
☐	☐	Visual Disturbances
☐	☐	History of Low/Mid Back Pain
☐	☐	History of Neck Pain
☐	☐	Arthritis
☐	☐	History of Alcohol Use
☐	☐	History of Tobacco Use

Surgies:_____________________
____
____
____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

Patient Name:_______________ **Boutwell Chiropractic Group P.C.** Date: ________

List of all medications & dosages (Include OTC & Supplements)

Medication:	Dosages:	Frequency:

Recent Covid Diagnosis or Vaccination: ______________________________

If patient is a minor, Parent/Guardian Permission to treat: Yes No

Name: ________________________ Signature:______________________________

For Office Use:

Describe your current problem and how it began:

____

____

____

____

____

Is this? Work Related Auto Related N/A Date Problem Began: _________________________

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are your symptoms present? 0-25% 26-50% 51-75% 76-100%

Can you perform your daily activities? Yes No (Describe) ______________________________

HAVE YOU HAD SPINAL X-RAYS, MRI, XT SCAN? No Yes **Date(s) Taken:** _____________

REGIONS TAKEN: ____

Patient Name:______________ Boutwell Chiropractic Group P.C. Date: ________

Auto Accident, Workers Comp, or Personal Injury (Please circle the correct answer)

Date of Accident: ______________ Time: _________ AM PM. Location of accident: __________________

Were you the: Driver Passenger Pedestrian

Where was the impact? Behind Right Side Left Side Front Parked

Did your car strike the other(s) involved? Yes No Undetermined

Did the other car strike yours? Yes No Undetermined

As a result of the accident, were traffic citations issued to you? Yes No

Check symptoms you have noticed since the accident:

☐ Headache	☐ Sleeping problems	☐ Lights bother eyes	☐ Diarrhea
☐ Neck Pain	☐ Head too heavy	☐ Loss of memory	☐ Feet cold
☐ Neck Stiff	☐ Pins & needles in arms	☐ Ear Ringing	☐ Hands cold
☐ Dizziness	☐ Pins & needles in legs	☐ Face flushed	☐ Stomach upset
☐ Back pain	☐ Numbness in fingers	☐ Buzzing in ears	☐ Constipation
☐ Nervousness	☐ Numbness in toes	☐ Loss of balance	☐ Cold sweats
☐ Tension	☐ Shortness of breath	☐ Fainting	☐ Fever
☐ Irritability	☐ Fatigue	☐ Loss of smell	☐ Chest pain
☐ Loss of taste	☐ Other ______________________________		

Did you require post-accident hospitalization? Yes No

Have you lost any days of work? Yes No If yes, what dates? ______________________

Since the accident have your symptoms: IMPROVED STEYED THE SAME. WORSENED

What type of vehicle were you driving: S M L CAR/TRUCK/SUV

What type of vehicle was the other vehicle involved: S M L CAR/TRUCK/SUV

Were you wearing a seatbelt: Yes No

Which direction were you looking at time of impact: AHEAD LEFT RIGHT DOWN UNCERTAIN

Did any part of your body contact the interior of the car? Y/N If yes: Your ________ hit the ___________.

Did you lose consciousness? Y/N

Patient vehicle movement: BACKING UP MOVING FORWARD STOPPED TURNING RIGHT/LEFT

Estimated speed of patient vehicle: <0 < 15 MPH 15-25 MPH 25-40 MPH 40-65 MPH >65 MPH

Damage to patient vehicle: HEAVY MODERATE SLIGHT NONE TOTALED UNKNOWN

Other vehicle movement: BACKING UP MOVING FORWARD STOPPED TURNING RIGHT/LEFT

Other vehicle estimated speed: <0 < 15 MPH 15-25 MPH 25-40 MPH 40-65 MPH >65 MPH

Damage to other vehicle: HEAVY MODERATE SLIGHT NONE TOTALED UNKNOWN

Was your vehicle towed: Y/N Police Report: Y/N Accident Report: Y/N EMS on Scene: Y/N

Have you received any tickets since the accident: Y/N If yes explain: ___________________________

Insurance Information (Please fill out this section in its entirety)

At-Fault Insurance Company Name _________________________ Phone Number _______________

Claims Mailing Address ____

Adjustor Name ______________________ Is there medical payment coverage on this claim? Yes No

Your Insurance Company Name ___________________________ Phone Number _______________

Do you have medical payments coverage on your auto policy? Yes No

Do you have an attorney that has advised you in this case? Yes No

If yes, attorneys name __________________________________ Phone Number _______________