LIVE YOUNG

PATIENT INFORMATION

Name: _____ Birthday (M/D/Y): _____ Age: _____ Gender: _____

Address: _____

Home Ph. #: _____ Cell: _____ Email: _____

Marital status: _____ # of Children: _____ Occupation:_____

Name of Medical Doctor: _____ Retired from _____ profession

Social Security #_____-_____-_____

DESCRIPTION OF ACCIDENT: **Date of Accident:** _____

1. Were you the: ☐ Driver or ☐ Passenger: ☐ Front, ☐ Rear Left, ☐ Rear Right
2. Was your: ☐ vehicle struck by another vehicle or ☐ did you strike another vehicle or ☐ both
3. What direction did the impact come from? ☐ Front ☐ Rear ☐ Left ☐ Right
4. Were you wearing your seatbelt? ☐ Yes / ☐ No
5. Did your head hit the headrest? ☐ Yes / ☐ No / ☐ Don't remember
6. Were you knocked unconscious at all? ☐ Yes / ☐ No
7. Did your body strike anything in the vehicle? ☐ Yes / ☐ No / ☐ Don't remember

   If yes, please list: _____ _____

   _____ _____

8. How did you feel immediately afterwards?

☐-Dizzy/Dazed ☐-Disoriented ☐-Nauseous ☐-Upset ☐-Weak ☐-Other _____

9. Did you go to the hospital/urgent care afterwards?

☐-Yes, immediately via ambulance ☐-No, I haven't been to the hospital/urgent care

☐-Yes, immediately via private transportation

☐-Yes, later that same day

☐-Yes, the next day -If yes, which facility? _____

10. At the hospital did the doctors take X-rays/CT scans?

-Yes, of my: ☐ head ☐ neck ☐ low back ☐ other_____ ☐ -No

11. What treatments were rendered at the hospital?

☐ -I was given pain medication/muscle relaxants: _____

☐ -I was given information on sprains/strains

☐ -I was given information on concussions

☐ -I was referred to call my primary care doctor

☐ -I was referred to a specialist provider: orthopedic surgeon neurosurgeon physical therapist

☐ -No treatment was rendered

☐ -Other: _____

12. Have you seen any other doctors as a result of this accident? ☐ Yes / ☐ No

13. Was a police report filed? ☐ Yes / ☐ No / ☐ Not Sure

14. Have you been in any motor vehicle crashes other than this one? ☐ Yes / ☐ No

-If yes, please list year, areas injured and treatments needed below:

_____

_____

_____

_____

15. Which of your normal day to day abilities have been affected by this crash? (Please limit to 3)

☐ -Bending/Lifting	☐ -Driving	☐ -Working	
☐ -Reading	☐ -Exercising	☐ -Walking	
☐ -Sitting	☐ -Using a computer	☐ -Washing dishes	
☐ -Cooking	☐ -Cleaning	☐ -Personal care	☐ -Other

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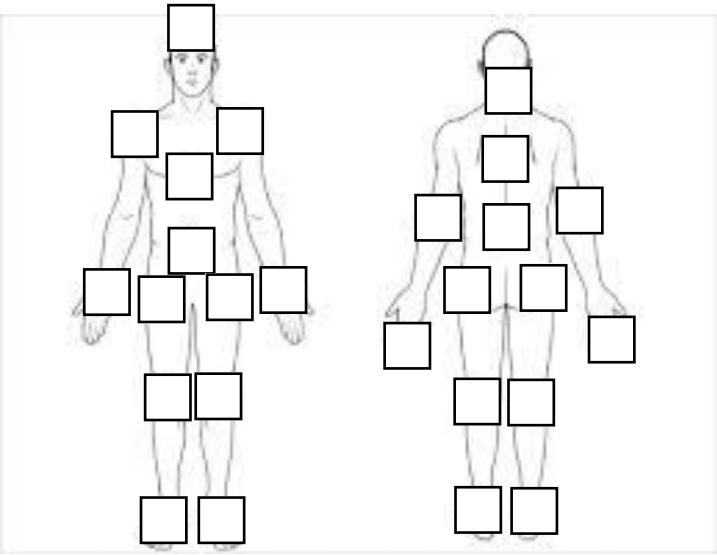
AREAS OF INJURY



1. Mark all areas that apply:

- X = sharp pain
- B = burning
- ... = numbness
- P = pins
- A = aching pain
- T = tight

Please list, from worst to best, the areas where you feel pain.

_____	☐ slight	☐ mild	☐ moderate	☐ severe
_____	☐ slight	☐ mild	☐ moderate	☐ severe
_____	☐ slight	☐ mild	☐ moderate	☐ severe
_____	☐ slight	☐ mild	☐ moderate	☐ severe
_____	☐ slight	☐ mild	☐ moderate	☐ severe
_____	☐ slight	☐ mild	☐ moderate	☐ severe

Have these areas ever been injured before? ☐ Yes / ☐ No

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OTHER SYMPTOMS

Since the accident have you noticed any other changes, such as:

☐-Fatigue ☐-Anxiety ☐-Sleeplessness ☐-Memory Loss ☐-Ringing Ears
☐-Fear of driving a car ☐-Irritability ☐-Headaches ☐-Confusion
☐-Increased thirst ☐-Increased urination ☐-Cravings ☐-Inability to Focus
☐-Other: _____ _____ _____ _____

FAMILY & PERSONAL HISTORY

Please list family members (or yourself) who have the following conditions:

Cancer:	Autoimmune disease:
Eczema:	Arthritis:
Diabetes:	Allergies:
Heart disease:	Asthma:
High blood pressure:	Addictions:
Stroke:	Liver disease:
Thyroid disease:	Mental illness:

Have you ever been treated by a chiropractor before? ☐ Yes / ☐ No

If yes, how long has it been since your last visit: _____

What treatments did you receive?

☐ Adjustments ☐ Electrical Stim ☐ Laser ☐ Soft Tissue Therapy

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Please list hospitalizations, surgeries, injuries, x-rays, CAT scans, MRIs, EKGs, etc.

Year: _____ Description: _____

Year: _____ Description: _____

List any allergies that you know of:

_____

_____

Please list all medications/dosages you are currently taking, denote with an * if it was prescribed bc of this accident:

1._____ 4. _____

2. _____ 5._____

3. _____ 6._____

Please list supplements you are currently taking:

1._____ 4. _____

2. _____ 5._____

3. _____ 6._____

office use below

Height _____ Weight _____ HR _____ BP_____/_____ Temp ____.___ O2% _____ Resp _____

Kinetisense AROM's

Cervical	**Lumbar**
Flexion	Flexion
Extension	Extension
Left Lateral Flexion	Left Lateral Flexion
Right Lateral Flexion	Right Lateral Flexion
Left Rotation	Left Rotation
Right Rotation	Right Rotation

Cancellation and missed visit policy

I understand it is my responsibility to attend all scheduled treatment visits. In the event I cannot make a scheduled visit, I will provide office staff with a minimum of 24 hours notice so that time can be dedicated to other patients in need of care. I understand that failure to follow this rule on more than 2 occasions will result in charges, at the normal cash rate of $55 per visit, for every visit I miss.

Informed Consent and Request for Chiropractic Care

As a patient, I have the right to be informed about my health condition(s) and recommended treatments. Dr. Kennedy will discuss the potential benefits, risks and hazards involved. After signing this consent form, I understand I can withdraw consent at any time.

I recognize that even the gentlest therapies may potentially have complications. Hence, the information I have provided is complete and inclusive of all health concerns and medications, including over-the-counter medications, supplements, and herbs and waive my right to hold Live Young PLLC, Dr. Kennedy and any treating staff members responsible for unwanted side effects of treatment.

I give my written consent for evaluation and treatment. I intend this as a consent form to cover my entire course of treatments including any future conditions for which I seek treatment.

_____
Printed Name

_____
Signature

_____
Date