**SHIN FAMILY CHIROPRACTIC, P.C.**

**SEUNGMOOK SHIN, D.C.**

1309 E. Township Line Rd

Blue Bell, PA 19422

Telephone: 484-684-7500

Date:

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| **Section 1: Patient Information** |
| PATIENT NAME | Date Of Birth | SEX M / F | MARITAL STATUS Single / Married / Other |
| SSN (optional) | H.PHONE | C.PHONE | E-MAIL |
| STREET | CITY | STATE | ZIP |
| EMPLOYMENT STATUS Employed Student Retired Other: |
| HEIGHT:  | WEIGHT:  |

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| **Section 2: Insurance Information** |
| **Primary Health Insurance** |
| INSURANCE COMPANY | INSURANCE TEL |
| MEMBER ID | INSURED’S NAME | RELATION TO INSURED | INSURED’S DOB |
| **Automobile Insurance (automobile accident only)** |
| INSURANCE COMPANY | INSURANCE TEL |
| CLAIM NO. | POLICY HOLDER | ADJUSTER NAME |

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| **Section 3: Accident History** |
| ACCIDENT DATE | ACCIDENT TIME | ACCIDENT Automobile Bus MotorcycleTYPE Bicycle Pedestrian Slip and fall | WORK RELATED ACCIDENT Yes / No |
| YOU WERE SEATED Driver’s Front Passenger Back Passenger | SEAT BELT Yes / No | AIR BAGS DEPLOYED Yes / No  |
| VEHICLE DAMAGE Mild / Moderate / Severe / Total Loss | WHERE ACCIDENT OCCURRED |
| HOW ACCIDENT OCCURRED |
| UPON IMPACT, YOUR BODY Tensed Whipped front-back Whipped side-side Twisted Hit against: |
| IMMEDIATELY AFTER THE IMPACT, Unconsciousness Nausea Dizziness Weakness Other:YOU EXPERIENCED Pain In: |
| WERE YOU TAKEN TO HOSPITAL AFTER THE ACCIDENT  Yes / No | IF YES, HOSPITAL NAME |
| STUDIES DONE AT HOSPITAL X-RAY MRI CT SCAN OTHER: |
| OTHER PHYSICIANS YOU SAW SINCE ACCIDENT | PHYSICIAN TEL | VISIT DATE |
| ATTORNEY NAME | PHONE NO | ADDRESS |
| **Section 4: Chief Complaints** |
| WHERE DO YOU HAVE PAIN? |
| IS PAIN DUE TO AN ACCIDENT?  Yes / No | PAIN STARTED ON | UNABLE TO WORK? Yes / No | HOW DID THIS PAIN START |
| MARK WHERE YOU HAVE PAIN | TYPE OF PAIN Sharp Dull Throbbing Numbness  Aching Shooting Burning Tingling  Cramps Stiffness  Swelling Radiating  Other:  |
| PAIN FREQUENCY Constant Frequent Intermittent Occasional (76-100%) (51-75%) (26-50%) (0-25%) |
| PAIN WORSENED Sitting Standing Walking Running   Bending Lying down Lifting Driving Other:  |
| PAIN RELIEVED BY |
| PAIN INTERFERES Work Sleep Recreating Daily Routine |
| PAIN SCALE NECK SHOULDER/ARM 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 100=no pain MID BACK LOW BACK1-3=mild pain 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 104-6=moderate pain HIP/LEG FOOT/ANKLE7-8=severe pain 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 109-10=extreme pain HEADACHE OTHER: 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 |
| **Section 5: Medical History** |
| PRIMARY PHYSICIAN NAME | PHYSICIAN TEL |
| CHECK ALL THAT APPLIES TO YOUR MEDICAL HISTORYAIDS/HIV+ Diabetes Infectious Mono Scarlet feverAnemia Diphtheria Kidney Disease ShinglesArthritis Epilepsy Liver Disease SmallpoxBack pain Glaucoma Measles StrokeBladder Infection Heart Disease Migraine Thyroid DiseaseBleeding Tendency  Hemorrhoids Mitral valve prolapse TuberculosisBlood/Plasma Transfusions Hepatitis Mumps UlcerBronchitis  Hernia Rheumatic fever Venereal DiseaseCancer High/Low blood pressure Pneumonia Whooping CoughChickenpox  Hives/Eczema  Polio Other:  |
| DESCRIBE ANY CURRENT OR PAST MEDICAL HISTORY NOT LISTED ABOVE |
| PAST SURGERIES | PAST ACCIDENTS/INJURIES |
| CURRENT MEDICATIONS |

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| **Section 6: Social History** |
| SMOKE OR TOBACCO PRODUCTS Yes / No | IF YES, HOW MUCH PER DAY  | IF NO, HAVE YOU IN THE PAST Yes / No |
| ALCOHOLS Yes / No | IF YES, HOW MUCH PER WEEK | IF NO, HAVE YOU IN THE PAST Yes / No |
| COFFEE OR TEA Yes / No | IF YES, HOW MUCH PER DAY | IF NO, HAVE YOU IN THE PAST Yes / No |
| EXERCISE Yes / No | IF YES, HOW MANY DAYS PER WEEK |

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| **Section 7: Patient Signature** |
| TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE OFFICE OF ANY CHANGE IN MY MEDICAL STATUS. |
| PATIENT SIGNATURE | DATE |