**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 Motorcycle  TYPE 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 10  0=no pain MID BACK LOW BACK  1-3=mild pain 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10  4-6=moderate pain HIP/LEG FOOT/ANKLE  7-8=severe pain 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10  9-10=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 |