



hawthorne chiropractic & healing arts

1222 se division street, portland, oregon 97202, p: 503-231-9879 f: 503-233-4732 amy lennon, dc • cliff marhoefer, dc

PERSONAL INJURY PATIENT HISTORY

Welcome to Hawthorne Chiropractic!
Please take a moment to provide us with the following information.
If you have any questions, please let one of us know.

TODAY'S DATE _____

ABOUT YOU

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Age _____ Date of Birth: _____

SSN: _____

Occupation _____ Daily # of hrs worked: _____

Work Activities: _____

Employer _____

How did you hear about us? _____

If a person referred you, we will thank them with a free 30-minute massage or chiropractic treatment.

PHONE NUMBERS

Home: _____

Work: _____

Is it OK to call you at Work Yes No

Mobile: _____

E-mail: _____

Emergency Contact

Name: _____

Relationship: _____

Home #: _____

Work and/or cell #: _____

Primary Care Physician: _____

their ph # (if you know it): _____

HISTORY OF OCCURENCE

In this accident, you were: Driver of the car Passenger in car Pedestrian Cyclist Other _____

Date of Accident: _____ Time: _____ AM PM

Did accident occur while you were on the job/working: yes No

Visibility at time of accident: Poor Fair Good

Road conditions at time of accident: Icy Rainy and Wet Clear Dark

Where did the accident happen? Street/Intersection _____ City _____ State _____

If this is a pedestrian, cyclist, other type of injury please describe below:

Driver of car: _____ What seat were you sitting in? _____

Who owns the car? _____ Year and model of car: _____

Your car: Hit another car Was hit in the: Right Left Rear Front

Type of accident: Head-on collision Broad side-collision

Rear-end collision Front impact, rear-ended car in front

Non-collision:



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Name: _____ DOB: _____ Date: _____

IMPACT/SEAT BELT/HEADREST/SPEED

Describe in your own words what happened to you upon impact: _____

Did you see the accident coming? Yes No

Did you brace for the impact? Yes No

Were seat belts worn? Yes No

Were shoulder harnesses worn? Yes No

Does your car have headrests? Yes No

If yes, what was the position of those headrests compared to your head before the accident?

Top of headrest even with **bottom** of head Top of headrest even with **top** of head

Top of headrest even with middle of neck

Was your car braking? Yes No

Was your car moving at the time of accident? Yes No

If yes, how fast would you estimate you were going? _____ MPH (estimate)

How fast was the other car travelling? _____ MPH (estimate)

Did your car strike any other cars or objects after the initial impact? Yes No

HEAD/BODY POSITION/ABLE TO MOVE BODY

Head/Body position at time of impact: Head turned: Right Left Head looking back Head straight forward

Body straight in sitting position Body rotated: Right Left

At the time of accident, recall what parts of your head or body hit what parts on the inside of your car: _____

As a result of the accident you were: Rendered unconscious Dazed, circumstances vague Shaken up but could function

Could you move all parts of your body? Yes

If no, what body parts could you not move and why? _____

Were you able to get out of the car and walk unaided? Yes

If no, why couldn't you get out of the car and walk unaided? _____



Name: _____ DOB: _____ Date: _____

SYMPTOMS FROM ACCIDENT

Did you get bleeding cuts or bruises? No

If yes. what bleeding cuts did you get from this accident? _____

If yes. what bruises did you get from this accident? _____

Please describe how you felt. *PLEASE BE SPECIFIC.*

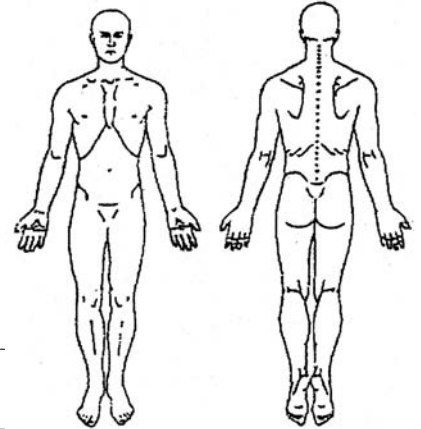
Immediately after the accident: _____

Later that Day Night: _____

The next day(s): _____

Check symptoms apparent since the accident:

- Headache
- Neck pain/stiffness
- Midback pain
- Low Back Pain
- Eyes sensitive to light
- Pain behind eyes
- Blurred vision
- Dizziness
- Fainting
- Ringing/buzzing ears
- Loss of balance
- Loss of smell
- Loss of taste
- Nausea
- Loss of memory
- Fatigue
- Tension
- Shortness of breath
- Irritability
- Depression
- Sleeping problems
- Numbness in toes
- Numbness in fingers
- Cold hands
- Cold feet
- Diarrhea
- Constipation
- Chest pain
- Nervousness
- Cold sweats
- Anxious
- other _____
- Shoulder
- Elbow
- Wrist/Hand
- Hip
- Knee
- Ankle/Feet



WORK STATUS HISTORY

Occupation: _____ Employer: _____

Have you missed time from work? Yes No

If Yes: Full time off work _____

If Yes: Part-time off work _____

Been unable to work since accident.

FIRST DOCTOR/HOSPITAL/CLINIC SEEN

Did you go to seek medical help immediately/soon after the accident? Yes No

If yes, how did you get there? Someone else drove me Drove own car Ambulance Police

DOCTOR/HOSPITAL/CLINIC SEEN: _____

Were you examined? Yes No Were X-rays taken? Yes No

Were you Treated? No or Prescribed medication? Name: _____

If yes, what treatment was given to you? _____

What benefits did you receive from the treatment? _____

Date of last treatment: _____

SECOND DOCTOR/CLINIC SEEN

DOCTOR 2/CLINIC SEEN: _____

Were you examined? Yes No Were X-rays taken? Yes No

Were you treated? No

If yes, what treatment was given to you? _____

What benefits did you receive from the treatment? _____

Date of last treatment: _____

THIRD DOCTOR/CLINIC SEEN

DOCTOR 3/CLINIC SEEN: _____

Were you examined? Yes No Were X-rays taken? Yes No

Were you treated? No

If yes, what treatment was given to you? _____

What benefits did you receive from the treatment? _____

Date of last treatment: _____



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Name: _____ DOB: _____ Date: _____

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stretching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lovemaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Recovery

How many hours are in your normal workday? _____

Please indicate on your daily job duties and any activities, which you are occasionally asked to perform.

- Standing Driving Operating equipment
- Sitting Twisting Work with arms above head
- Walking Crawling Typing
- Lifting Bending Stooping

Other: _____

Please list any past auto accidents here: _____



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Name: _____ DOB: _____ Date: _____

Prior SIMILAR SYMPTOMS

Did you have any physical complaints **just before the accident**? No

If yes, what physical symptoms did you have. **Just before the accident?** _____

PRIOR to this accident, have you **EVER** had symptoms similar to what you're experiencing now? No

If yes, please explain (briefly include past falls, injuries, accidents, operations, etc.): _____

ACTIVITIES OF DAILY LIVING

Do you notice any activities of your home daily routines that are different now than from before the accident? No

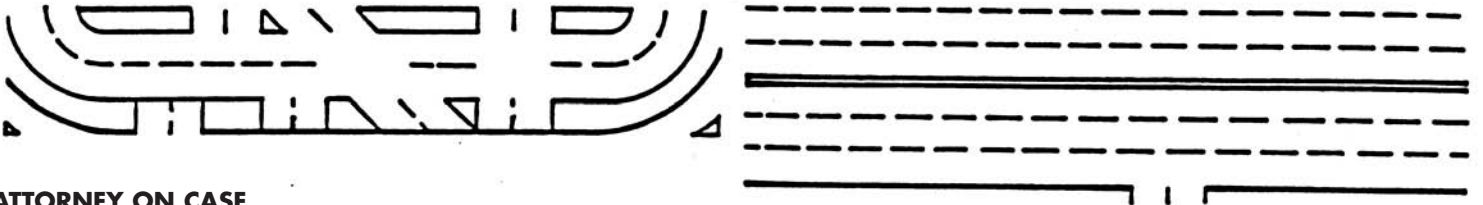
If yes, list them as:

Those activities that you are now unable to do are (be specific): _____

Those activities that are now painful to do are (be specific): _____

Those activities that are now difficult to do are (be specific): _____

INDICATE ON THESE DIAGRAMMS HOW THE ACCIDENT HAPPENED



ATTORNEY ON CASE

Do you have an attorney on this case? No

If yes, who? Name: _____

Address: _____ City _____ State _____ Zip _____

AUTOMOBILE ACCIDENT - INSURANCE DATA - check in at frontdesk w/questions

Patient's Insurance Company Information

Company Name: _____ PH: _____ Policy # _____

P.O. Box/Street Number: _____ Adjuster's Name: _____

City/State/Zip: _____ Claim #: _____

Insured's Insurance Information

Insured's name if other than patient: _____ PH: _____

Company Name: _____ PH: _____ Policy # _____

P.O. Box/Street Number: _____ Adjuster's name: _____

City/State/Zip: _____ Claim #: _____

Other Driver's Insurance Information

Other Driver's Name (if another car was involved): _____ PH: _____

Company Name: _____ PH: _____ Policy #: _____

P.O. Box/Street Number: _____ Adjuster's Name: _____

City/State/Zip: _____ Claim #: _____

Health History

When was your most recent full physical, including heart/lung/BP, etc.: _____

Results: _____

If you ever had a listed symptom in the *past*, please check that symptom in the Past column, If you are presently troubled by a particular symptom, check that symptom in the *Present* column.

Past Present

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Neck Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Upper Arm or Elbow |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Upper Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Upper Leg or Hip |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Lower Leg or Knee |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Ankle or Foot |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling/Stiffness of Joint(s) |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting, Visual Disturbance, Nausea |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Headache |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular Incoordination |
| <input type="checkbox"/> | <input type="checkbox"/> | Tinnitus (Ear Noises) |
| <input type="checkbox"/> | <input type="checkbox"/> | Rapid Heart Beat |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Sinusitis |
| <input type="checkbox"/> | <input type="checkbox"/> | General Fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Bladder Control |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation/Irregular Bowel Habits |
| <input type="checkbox"/> | <input type="checkbox"/> | Soreness/Lumps |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Swallowing |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn/Indigestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Dermatitis/Eczema/Rash |

Past Present

- | | | | |
|--------------------------|--------------------------|---|------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol use | How often: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug or Alcohol Dependence | |
| <input type="checkbox"/> | <input type="checkbox"/> | Vitamins/herbs | |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgical Procedures | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Coffee/Tea/ Caffeinated soft drink, cups per day: | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you adhere to any dietary restrictions? | |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you a smoker? How long? | _____ |
| | | How much? | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a permanent disability rating? | |
| | | Location | _____ |
| | | Date rating received | ____/____/____ |
| | | Rating percentage | _____% |

Men only

- | | | |
|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate exam, including blood test |
| <input type="checkbox"/> | <input type="checkbox"/> | Problems with prostate |

Women only

- | | |
|--------------------------|--|
| <input type="checkbox"/> | Irregular Periods |
| <input type="checkbox"/> | Periods Have Ceased |
| <input type="checkbox"/> | Profuse Menstrual Flow |
| <input type="checkbox"/> | Vaginal Discharge |
| <input type="checkbox"/> | PMS |
| <input type="checkbox"/> | Birth Control Pill |
| <input type="checkbox"/> | Periods Accompanied by Abdominal Pain |
| <input type="checkbox"/> | Severe and Incapacitating (you go to bed) |
| <input type="checkbox"/> | Gynecological or Abdominal Surgeries |
| <input type="checkbox"/> | Breast Soreness/Lumps |
| <input type="checkbox"/> | Pregnancy |
| | Have Any Children? <i>If yes: what ages:</i> |

Your current weight: _____ lbs. / Height: _____ feet _____ inches

Please list anything that you may be allergic to: _____

List any serious accident dates: _____

Please list dates of X-Rays, CAT Scans, MRI's or any other studies done: _____

Please list all medicines you are presently taking, and why: (Use back if necessary.) _____

Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the past or are presently troubled by a listed disorder.

Past Present

- | | | |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems |

Past Present

- | | | |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Anorexia |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Defect/Murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Stones |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder Infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disorders |

Past Present

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Colitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritable Colon |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema (chronic lung disorders) |
| <input type="checkbox"/> | <input type="checkbox"/> | Unexplained weight loss/gain, fever, fatigue (circle) |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

Do you have any known contagious diseases at this time? If yes, What: _____

Name: _____

DOB: _____