

CONFIDENTIAL PATIENT INFORMATION

Name _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Marital Status ☐ M ☐ S ☐ D ☐ W Number Of Children _____ Email Address _____

Your Occupation _____ Employer _____

Employer Address _____ Work Phone _____

Name Of Spouse/Parent _____ Emergency Contact _____

Referred By _____ Purpose Of This Appointment _____

Injury Due To ☐ Auto Accident ☐ Other _____ Date Of Accident _____

Location Of Accident _____ State _____

Your Insurance Company _____ Name Of Insured _____

Insurance Of Person Responsible For Accident _____

Name Of Insured Person Responsible For Accident _____

Have You Contacted Your Insurance Company About This Injury ☐ Yes ☐ No

Have You Been Contacted By The Other Persons Insurance About This Injury ☐ Yes ☐ No

Do You Have An Attorney That Has Advised You In This Case ☐ Yes ☐ No Attorneys Name _____

Attorney Address _____ Phone _____

Dates Missed At Work Due To These Injuries _____

List The Extent Of Your Injuries As You Know Them _____

Check Symptoms You Have Noticed Since The Accident:

<input type="checkbox"/> Headaches	<input type="checkbox"/> Lower Back Pain	<input type="checkbox"/> Leg Pain
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Sleeping Trouble	<input type="checkbox"/> Numbness/Tingling In Feet
<input type="checkbox"/> Cold Hands	<input type="checkbox"/> Cold Feet	<input type="checkbox"/> Leg Numbness/Tingling
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Arm Pain	<input type="checkbox"/> Nausea
<input type="checkbox"/> Ringing In Ears	<input type="checkbox"/> Tingling/Numbness In Arms	<input type="checkbox"/> Urinary Control Changes
<input type="checkbox"/> Light Bothers Eyes	<input type="checkbox"/> Tingling/Numbness In Hands	<input type="checkbox"/> Bowel Control Changes
<input type="checkbox"/> Confusion	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> Memory Loss

Were You Treated At The Hospital Emergency Room For This Accident? ☐ Yes ☐ No When _____

What Treatment Did They Give Or Recommend? _____

_____ Did You Go By ☐ Ambulance ☐ You Drove ☐ Someone Took You

Name Of First Doctor You Saw For These Injuries (If Different Than Emergency Room) _____ Date First Visit _____

Date Last Visit _____ What Treatment Was Given _____

Did You Benefit From This Treatment? _____

Name Of Second Doctor Seen _____ Date Of First Visit _____

Date Last Visit _____ What Treatment Was Given _____

Did You Benefit From This Treatment _____

Location Of Any Cuts Or Bruises You Received In This Accident _____

Were You Able To Get Out Of Your Vehicle And Walk After The Accident? _____ Yes _____ No If No Why _____

Did You Strike Your Head During The Accident _____ Yes _____ No If Yes On What _____

Did You Lose Consciousness After The Accident? _____ Yes _____ No For How Long _____

Describe How You Felt The Day Of The Accident _____

The Next Day _____

Were You The _____ Driver _____ Passenger _____ Front Seat _____ Back Seat _____ Left Side _____ Right Side _____ Center

Were You Wearing A Seat Belt _____ Yes _____ No _____ Lap Belt _____ Lap And Shoulder Belt

Was The Accident Impact From The _____ Front _____ Back _____ Side _____ Left _____ Right

Body Position At The Time Of Impact _____ Not Sure _____ Head Turned Left _____ Head Turned Right _____ Head Straight Ahead

_____ Body Turned To The Left _____ Body Turned To The Right _____ Body Straight Ahead _____ Other _____

Did You Strike Anything In The Car With Any Part Of Your Body _____ Yes _____ No Describe _____

What Kind Of Vehicle Were You In? _____

What Kind Of Vehicle Hit You? _____

Were You Aware The Accident Was Coming _____ Yes _____ No Were You Able To Brace Yourself _____ Yes _____ No

How Fast Would You Estimate Your Vehicle Was Going When The Accident Occurred _____ Unknown _____ Stopped _____ MPH.

How Fast Would You Estimate The Speed Of The Other Vehicle When The Accident Occurred _____ Unknown _____ Stopped _____ MPH.

Were Citations Issued To The Driver Of Your Car _____ Yes _____ No To The Other Driver _____ Yes _____ No

Have You Been Involved In Any Other Auto Accidents _____ Yes _____ No If Yes When _____

Other People Injured In Your Vehicle _____ If Female Are You Pregnant? _____ Yes _____ No _____

Name of Your Primary Medical Doctor _____ With what Office/Clinic _____

Approximate Date Last Seen by your MD _____ Years _____ Months

Have You Ever Been Diagnosed With Any Serious Illnesses? _____

_____ Cancer

_____ Diabetes

_____ Hypertension

_____ Stroke

_____ Tuberculosis

_____ Mental Illness

What Surgeries Have You Had _____

_____ When _____

What Medications Are You Taking _____

I Understand And Agree That Health And Accident Insurance Policies Are An Arrangement Between An Insurance Carrier And Myself. Furthermore, I Understand That The Lembke Chiropractic Clinic Will Do Their Best To Prepare Any Necessary Reports Or Forms To Assist Me In Making Collections From The Insurance Company And That Any Amount Authorized To Be Paid Directly To The Lembke Chiropractic Clinic Will Be Credited To My Account Upon Receipt. However I Clearly Understand And Agree That All Services Rendered Me Are Charged Directly To Me And I Am Personally Responsible For Payment In Full.

Patient's Signature _____ Date _____ S.S. # _____

Information Taken By _____ Date _____

Review of Systems

Have you had or do you have any of the following conditions? (check only those that apply)

Past

Past

Menstrual difficulties

Prostate trouble

Sexual function difficulties

Rheumatoid arthritis

Diabetes

Headaches

Seizures

Multiple sclerosis

Do you have any of the following life style habits?

No Yes

Epilepsy

Tuberculosis

Drink alcohol _____ **drinks per week**

Thyroid trouble

Smoke Tobacco _____ packs per week

Allergies

Use recreational/illegal drugs_____ **type**_____

Shortness of breath

Drink caffeinated drinks _____ per day

Asthma

Exercise	Times per week
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Indigestion

what type _____

Ulcers

Constipation

Diarrhea

Sudden unexpected weight loss

Osteoporosis

Difficulty releasing urine

Difficulty holding urine

Mental illness describe

Cancer of what _____ **when** _____

Heart Disease describe	when
Coronary artery disease	when the arteries that supply the heart with blood become narrowed or blocked
Myocardial infarction (heart attack)	when a part of the heart muscle dies due to a lack of blood flow
Angina	when the heart muscle experiences chest pain or discomfort due to reduced blood flow
Heart failure	when the heart is unable to pump blood effectively to the rest of the body
Arrhythmia	when the heart's electrical system malfunctions, causing irregular heartbeats
Valvular disease	when the heart's valves do not open or close properly, affecting blood flow
Pericarditis	when the pericardium, the sac surrounding the heart, becomes inflamed
Cardiomyopathy	when the heart muscle becomes enlarged and weakened
Conduction system disorders	when the heart's electrical system is affected, leading to abnormal heart rhythms
Coronary artery bypass graft (CABG)	when a blocked coronary artery is bypassed using a blood vessel from another part of the body
Percutaneous coronary intervention (PCI)	when a blocked coronary artery is treated using minimally invasive techniques, such as angioplasty or stenting
Heart transplantation	when a diseased heart is replaced with a healthy heart from a donor
Cardiac catheterization	when a catheter is inserted into the heart to diagnose or treat various conditions
Implantable cardioverter-defibrillator (ICD)	when a device is implanted in the chest to monitor and treat abnormal heart rhythms
Cardiac resynchronization therapy (CRT)	when a device is implanted to help the heart pump more effectively by coordinating the timing of the heart's contractions
Transcatheter aortic valve replacement (TAVR)	when a diseased aortic valve is replaced using a minimally invasive technique
Minimally invasive cardiac surgery	when heart surgery is performed using small incisions and minimally invasive techniques
Cardiac rehabilitation	when a structured program of exercise, education, and support is provided to help heart patients recover and improve their overall health
Heart health and prevention	when focusing on maintaining a healthy lifestyle, including regular exercise, a balanced diet, and avoiding tobacco and excessive alcohol consumption

Date _____ **Reviewed** _____

2/17/05



Lembke Chiropractic Clinic

Address: 11015 NE 4th Plain Rd Ste B, Vancouver, WA 98662

Phone: (360) 892-0451

Website: <https://www.vancouverwashingtonchiropractor.com/>

Hours

Monday 8:00 AM - 6:00 PM

Tuesday 8:00 AM - 12:00 PM

Wednesday 8:00 AM - 6:00 PM

Thursday 8:00 AM - 12:00 PM

Friday 8:00 AM - 6:00 PM

