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:

____Headaches	____Lower Back Pain	____Leg Pain
____Neck Pain	____Sleeping Trouble	____Numbness/Tingling In Feet
____Cold Hands	____Cold Feet	____Leg Numbness/Tingling
____Dizziness	____Arm Pain	____Nausea
____Ringing In Ears	____Tingling/Numbness In Arms	____Urinary Control Changes
____Light Bothers Eyes	____Tingling/Numbness In Hands	____Bowel Control Changes
____Confusion	____Mid Back Pain	____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_____

Scott Lembke, D.C. 11015 NE 4th Plain Suite B Vancouver WA 98662 (360) 892-0451

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)***

Presently	Past		Presently	Past	
____	____	High blood pressure	____	____	Menstrual difficulties
____	____	Low blood pressure	____	____	Prostate trouble
____	____	Strokes (CVA)	____	____	Sexual function difficulties
____	____	Dizziness	____	____	Rheumatoid arthritis
____	____	Ringing in the ears	____	____	Diabetes
____	____	Sinus trouble			
____	____	Headaches			
____	____	Seizures			
____	____	Multiple sclerosis			
____	____	Epilepsy			
____	____	Tuberculosis			
____	____	Thyroid trouble			
____	____	Allergies			
____	____	Shortness of breath			
____	____	Asthma			
____	____	Indigestion			
____	____	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_____

Do you have any of the following life style habits?

No	Yes	
____	____	Drink alcohol_____drinks per week
____	____	Smoke Tobacco _____packs per week
____	____	Use recreational/illegal drugs_____type
____	____	Drink caffeinated drinks _____per day
____	____	Exercise _____Times per week

what type_____

_____

_____

Patient name _____ *Date*_____ _____Reviewed

Scott Lembke, D.C. 11015 NE 4th Plain Suite B Vancouver, WA 98662 (360) 892-0451 2/17/05

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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