648 N. Alameda Blvd. Las Cruces, NM 88005
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www.mychirolovesme.com

CONFIDENTIAL HEALTH HISTORY

Name:_____Date of birth:_____Sex: Male/Female
Mailing Address:_____City:_____State:___Zip:____
Home phone:_____Work Phone:_____Cell Phone:_____
Drivers license #:_____State:____Expiration date:_____Married/Single
Social security #:_____Employer:_____
In case of emergency, please notify:_____Phone #:_____

Accident date:_____Time:_____Location:_____
Were you taken to the hospital? Yes/No By ambulance? Yes/No
Name and location of hospital, if applicable:_____
What treatment was rendered at the hospital:_____
_____
Please describe, to the best of your knowledge, what injuries you received in this accident:_____
_____
_____

Where were you seated in the vehicle: Passenger/Driver/Front/Back
Were you aware of the approaching collision prior to impact? Yes/No
Did you lose consciousness (black out) upon impact? Yes/No
Were you wearing a seatbelt? Yes/No If yes: Lap/Shoulder-Lap seatbelt
Road conditions at the time of impact? Wet/Dry/Ice/Other
What type of vehicle were you in? (Make/Model)_____
Estimated speed of the other vehicle(s) at time of impact_____
Describe other vehicle(s) involved (Make/Model)_____
Please describe, to the best of your knowledge what happened during this accident:_____
_____
_____

On what part of the automobile did the following body part hit?

Head_____ Chest_____
Right/Left shoulder_____ Right/Left arm_____
Right/Left hip_____ Right/Left leg_____
Right/Left knee_____ Other_____

If you have been in previous accidents, please list the year of each:_____
Please check off any symptoms you are having:

___Low back problems
___Pain between shoulders
___Neck problems
___Arm problems
___Leg problems
___Swollen joints
___Painful joints
___Stiff joints
___sore muscles
___Weak muscles
___Walking problems
___Ruptures
___Numbness
___Loss of feeling
___Paralysis
___Dizziness
___Fainting
___Headaches
___Muscle jerking
___Convulsions
___Forgetfulness
___Confusion
___Depression
___Broken bones

Are you pregnant? Yes/No
Could you be pregnant? Yes/No
Genito-urinary problems:_____Female problems:_____
Gastro-intestinal problems:_____Eye/Ear/Nose/Throat:_____
Cardio-vascular/respitory:_____
Comments:_____
_____
_____
_____

INSURANCE INFORMATION:
This MUST be filled out completely!

Insurance carrier:_____Agent:_____Phone:_____
Address:_____
Policy/Claim #:_____
Is there a "managed care" provision on this policy? Yes/No/Don't know

Financial Policy:

Insurance policies are contracts between you and your insurance company. The doctor can in no way alter the contract nor guarantee your payments by the insurance company. We will fill out necessary forms for your insurance company. Regardless of this service, however, the patient or guardian is ultimately responsible for payment of all fees.

I understand and agree that all fees for professional services rendered on my behalf are my personal responsibility.

Signed:_____Dated:_____