648 N. Alameda Blvd. Las Cruces, NM 88005
Office: 575-521-0022 Fax: 575-521-0033
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 the 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 involving **this** accident:

__Low back problems
__Pain between shoulders
__Neck Problems
__Arm Problems
__Leg Problems
__Swollen Joints
__Painful Joints
__Stiff joints
__Sore Joints
__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 problems:_____
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

ATTORNEY INFORMATION:

Please fill out if you are going through an attorney

Attorney's Name:_____
Firm Name:_____
Address:_____ Phone:_____

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. 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:_____Date:_____