Pomperaug Chiropractic
and Holistic Center, PC
3 Pomperaug Office Park, Suite 103
Southbury, CT 06488 (203) 264-3583

Patient History

Name_____ Date_____

Address_____ City_____

State_____ Zip_____ Home Phone_____ Cell_____

Work phone_____ Date of Birth_____ Age_____

Occupation_____ Employer_____

Marital Status S M D W Number of Children and Ages_____

Social Security #_____ E-Mail Address_____

Referred By_____ and_____

Name of Emergency Contact_____ Phone #_____

General Health Information

Height_____ Weight_____ Left/Right Handed Do you have a Pacemaker? Yes / No

Have you ever received chiropractic care before? Yes / No Drs. Name_____
Have you undergone previous chiropractic or physical therapy during this calendar year? _____
List any diseases or health conditions you now have, or have been treated for in the past. (Give a brief description):_____
_____
List any known allergies:_____
List any other traumas or injuries: _____
List any hospitalizations or surgeries: _____
When was your last complete physical?_____ Blood Tests _____ X-rays _____
Other Tests (describe) _____ Results?_____
Who is your primary doctor?_____ Address_____ Phone_____
Date of last visit to primary doctor:_____ Reason for visit:_____

Family History - Check all that apply

	Stroke	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Mother's Side	___	___	___	___	___	___
Father's Side	___	___	___	___	___	___

Medical Release/Assignment of Benefits

I authorize Pomperaug Chiropractic & Holistic Center, PC to release any Protected Health Information necessary to process my claims for health care benefits. I agree to assign the benefits of my insurance carrier to Pomperaug Chiropractic Center. I understand that I am fully responsible for any unpaid or unassigned portion of charges incurred at this office. Regardless of insurance status, charges for services rendered are ultimately the patient's responsibility.

Permission to Communicate Confidential Health Information

I authorize Pomperaug Chiropractic & Holistic Ctr., PC to communicate confidential health Information to me via the following confidential formats:
_____ Email Listed Above; ____Voicemail/Answering Machine at the following number: _____;
_____Only speak directly with me!

Patient's Signature _____ **Date**_____
(Parent or guardian of minor)

AUTOMOBILE ACCIDENT REPORT – Pomperaug Chiropractic Center

Name: _____ Today's Date: _____

Accident information: Date of accident: _____ Time of accident: _____

Location: _____

Description of Accident: _____

_____

_____

History of Injury:

Were you: Driver _____ Passenger _____

Auto struck: Drvr Side _____ Front _____ Back _____ Psgr Side _____

At impact: Turning L _____ Stopped _____ Moving _____ Turning R _____

Did the impact of the collision force your vehicle to impact another vehicle or object: _____

If so, explain: _____

Model of vehicle: Yours _____ Other _____

Traffic citation issued to: You _____ Other Drive _____

Was police report made: Yes _____ No _____

Did you see the accident coming: Yes _____ No _____

Were seatbelts worn: Yes _____ No _____

Were headrests in use: Yes _____ No _____

Were you thrown from your seat: Yes _____ No _____

Were you thrown against any part of the car: Yes _____ No _____

What parts: _____

Upon impact was there a "blinding" or "explosion" sensation in your head: Yes _____ No _____

Were able to get out of the car and walk: Yes _____ No _____

Were you conscious at all times: Yes _____ No _____

Could you move all parts of your body: Yes _____ No _____

State which areas of your body hurt immediately after the accident: _____

Injury treatment and follow-up:

Was an ambulance called: Yes _____ No _____

Did you go to a hospital: Yes _____ No _____

If yes, when: _____

Name of hospital: _____

Name of Doctor: _____

Treatment given: _____

_____

_____

Admitted: _____ How long: _____

Did you see any other Doctors: Yes _____ No _____

Name, Specialty, Treatment, Dates, Results:

_____

_____

_____

Rate your symptoms on a scale from 0–10: (0=None, 10=Intolerable), please circle: **1 2 3 4 5 6 7 8 9 10**

Since the injury, are the symptoms: Same _____ Worse _____ Improving _____

What discomfort did you have the first evening: _____

Were you able to sleep that night: Yes _____ No _____

What discomfort did you have the next day: _____

_____

Comments: _____

_____

Did your injuries cause you to miss time from work? Yes _____ No _____

If so what were the dates of time missed? _____

Did you ever have these or similar symptoms before? Yes _____ No _____

Have you retained an attorney or are you considering doing so? Yes/No Please discuss with front desk .

Signature _____ Date _____