Clayton & Roberts Chiropractic

917 E. Country Hills Drive Suite 4 South Ogden, UT 84403
Phone (801)621-1668 Fax (866)723-7266

Today's date _____

First Name_____ Middle Initial_____ Last Name _____
Birth date _____ Height _____ Weight _____Gender: M F
Address _____
Phone number_____ E-Mail address_____
Occupation _____ Have you seen a chiropractor before: Y N
Are you pregnant: Y N N/A

Please list any allergies (including allergies to medications):

Please list any surgeries you have had:

Please list your past medical history, i.e. cancer, high blood pressure, diabetes, heart conditions, stroke, osteoporosis, etc.:

Please list any medications you are taking and reason for taking them:

Please list any relevant family history, i.e. cancer, high blood pressure, diabetes, heart conditions, stroke, osteoporosis, etc.:

Please list any injuries or traumas you have had, i.e. car accident, work injury, sports, etc.:

Clayton & Roberts Chiropractic

917 E. Country Hills Drive Suite 4 South Ogden, UT 84403
Phone (801)621-1668 Fax (866)723-7266

Social History

I am employed: Y N I have normal bowel habits: Y N I use Tobacco products Y N
I exercise regularly: Y N I have normal bladder function: Y N I have high stress: Y N
I have a healthy diet: Y N I drink alcohol: Y N
I get enough sleep: Y N I use drugs: Y N

Please describe your complaints below:

Location of complaint	Onset of complaint	Cause of complaint	Description of complaint	% of the day complaint bothers you	Rate your pain 0-10
Example: Neck	*Monday last week*	*Car accident*	*Sharp, stabbing, ache*	*80%*	*O= no pain 10= worst pain you can imagine*

Review of Systems

General-
□ Unexpected weight loss
□ Fever
□ Loss of appetite
□ Fatigue
□ Feeling generally sick
□ None of the above

Eyes-
□ Sensitivity to light
□ Visual disturbances
□ Blurred vision
□ None of the above

Ears-
□ Decreased hearing
□ Ringing in ears
□ Earache
□ Drainage
□ None of the above

Nose-
□ Stuffiness
□ Discharge
□ Itching
□ Hay fever
□ Nosebleeds
□ Sinus pain
□ None of the above

Throat-
□ Bleeding
□ Dentures
□ Sore tongue
□ Dry mouth
□ Sore throat
□ Hoarseness
□ Thrush
□ Non-healing sores
□ None of the above

Cardiovascular-
□ Palpitations
□ Shortness of breath
□ Chest pain
□ Chest tightness
□ None of the above

Respiratory-
□ Cough
□ Shortness of breath
□ Painful breathing
□ Wheezing
□ None of the above

Gastrointestinal-
□ Swallowing difficulties
□ Heartburn
□ Change in appetite
□ Nausea
□ Change in bowel habits
□ Rectal bleeding
□ Constipation
□ Diarrhea
□ None of the above

Urinary-
□ Frequency
□ Urgency
□ Burning or pain
□ Blood in urine
□ Incontinence
□ Change in
urinary strength
□ None of the above

Skin-
□ Rashes
□ Lumps
□ itching
□ Dryness
□ Color changes
□ Hair and nail changes
□ None of the above

Neurologic-
□ Dizziness
□ Fainting
□ Seizures
□ Weakness
□ Numbness
□ Tingling
□ Tremor
□ None of the above

Psychiatric-
□ Nervousness
□ Stress
□ Depression
□ Memory loss
□ None of the above

Clayton & Roberts Chiropractic

917 E. Country Hills Drive Suite 4 South Ogden, UT 84403
Phone (801)621-1668 Fax (866)723-7266

Auto accident questionnaire

Name_____ Date:

Auto accident date :_____ Time of accident:_____
Type of vehicle you were in_____
Did you have your seatbelt on?
Did the airbags go off?
Did you have your head turned or looking straight ahead during the collision?

Were you the:

- □Driver
  - □Both hands on the wheel
  - □Right hand on the wheel
  - □Left hand on the wheel
- □Driver of a motorcycle
- □Front Passenger
- □Back Passenger
- □Other: _____

What was your vehicle doing at the time of the accident i.e. stopped at a light, slowing down, etc.?

What was the first area of impact for your vehicle?

If accident involved another vehicle, please describe the opposing vehicle type:

Approximate speed of the opposing vehicle _____
Approximate speed of your vehicle _____

Were you aware the impact was coming and able to brace?

Which position was your headrest in? □Middle □High □Low □Unknown

Clayton & Roberts Chiropractic

917 E. Country Hills Drive Suite 4 South Ogden, UT 84403
Phone (801)621-1668 Fax (866)723-7266

How did you feel after the accident?

Did you go to the Hospital: Y N

If so, were you admitted: □At time of accident □At a later time

Transported to hospital: □Ambulance □Life Flight □Police Car □Private Transportation

What hospital did you go to?

How were you injured?

□Thrown from Vehicle	□ By seatbelt	□ Hit another passenger
□ Hit back of front seat	□Hit console	□ Hit dashboard
□ Hit the door	□Hit the roof of car	□ Hit the steering wheel
□ Hit window	□ Hit windshield	□ Other_____

Please list all medical facilities you have been to for this accident:

Are you able to work?

Are you able to perform household chores?

Are you experiencing any of the following since the accident?

□ Visual disturbances	□ Loss of smell	□ Dizziness
□ Sensitivity to light	□ Loss of taste	□ Nausea
□ Ringing in ears	□ Difficulty concentrating	□ Vomiting
□ Loss of consciousness	□ Memory loss	□ None of the above