Thiele Chiropractic & Wellness File #: ______
Patient Name: _________________________________ Date: ___/___/______

Personal Injury/ Home Injury

Please answer all questions completely

This information is considered confidential. We need this information because we care enough to want to know, and to help us determine if chiropractic care can benefit you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case and we will refer you to the most appropriate provider to help you. In order for us to understand your condition properly, please be as neat and thorough as possible while completing this form. Thank you.

Date of the injury? _____/_____/_______ Time of Day _________ AM/PM
Where exactly did the injury occur (location or address)? ____
____

Please explain in detail how your injury occurred: ____
____
____

What were the time and date of injury? ____

What symptoms did you have immediately after the injury? ______________________________________
____

List the extent of your injuries as you know them: ____
____
____

Check symptoms you have noticed since the injury:

☐ Headache	☐ Fainting	☐ Tension	☐ Bowel Changes
☐ Dizziness	☐ Light Sensitivity	☐ Irritability	☐ Sleep Problems
☐ Head Seems Heavy	☐ Buzzing/Ringing in Ears	☐ Nervousness/ Anxiety	☐ Difficulty Concentrating
☐ Neck Pain	☐ Pins and Needles in Arms	☐ Depression	☐ Shortness of Breath
☐ Neck Stiffness	☐ Pins and Needles in Legs	☐ Fatigue	☐ Stomach Pain
☐ Back Pain	☐ Numbness in Fingers	☐ Loss of Memory	☐ Cold Sweats
☐ Rib Pain	☐ Numbness in Toes	☐ Loss of Balance	☐ Face Flushed
☐ Chest Pain	☐ Cold Feet	☐ Loss of Smell	☐ Fever
☐ Arm/Leg Pains	☐ Cold Hands	☐ Loss of Taste	

Symptoms other than above: ____
Did you have any similar symptoms or complaints before the injury? ☐Yes ☐No
If Yes, describe: ____
____

Were you knocked unconscious? ☐Yes ☐No **If Yes**, for how long? ___________________________

Where were you taken after the injury? ____

Hospitalized? ☐Yes ☐No **If Yes**, admitted? ☐Yes ☐No How Long? _______________________

Name of Hospital: ____

What was the diagnosis? ____

What treatment was given? ____

Was any other doctor consulted after your injury? ☐Yes ☐No

If Yes, Name of Doctor and Specialty: ____

What was the diagnosis? ____

What treatment was given? ____

How long ago did you see the doctor? ____

Since the injury, are your symptoms getting: ☐Worse ☐Improving ☐Staying the Same

Before your injury were you capable of working on an equal basis with others your age? ☐Yes ☐No

Are your work activities restricted as a result of this injury? ☐Yes ☐No

Are your recreational activities restricted or limited as a result of this injury? ☐Yes ☐No

Please provide information about the insurance company responsible for payment of this injury?

Name: ______________________________ Insurance Company: ___________________________________

Policy No. _____________________________________ Phone #: __________________________________

Name of your insurance adjustor ____

Have you retained an attorney? ☐Yes ☐No

If Yes, Name and Address: ____

____

Patient's Printed Name: ______________________________________ **DOB**: _______________

Patient Signature: ____ **DATE**: ______________

Doctor Signature: ____ **DATE**: ______________