IF YOURS IS AN ACCIDENTAL INJURY PLEASE
COMPLETE THE FOLLOWING QUESTIONS

Date of Accident:_____Hour _____AM_____PM Location _____

How Did Accident Occur? ____Auto Collision _____On-The-Job _____Other _____

If an Auto Collision, Please Describe The Circumstances _____

_____

_____

Did You Report the Injury to your Foreman or Employer? _____ Yes _____ No

Did He (They) Recommend Care at Our Office? ____ Yes ____ No

If Auto Accident, Were you ____Driver ____ Passenger ____ Pedestrian

If Auto Collision Were you Struck From ____Behind ___Right Side ___Front ___Auto Was Parked

Did Your Car Strike The Other(s) Involved? ___Yes ___No

Did The Other Car Strike Yours? ___Yes ___No ___ Undetermined

As a Result of the Accident, Were Traffic Citations Issued to You? ___ Yes ___ No

To the Driver of The Other Car ___Yes ___ No To The Drive of Your Car ___Yes ___ No

List the Extent of the Injuries as You Know Them _____

_____

_____

Did you Require Post-Accident Hospitalization ? ___ Yes ___NO

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT

__Headache	__Irritability	__Numbness in Toes	__Face Flushed
__Neck Pain	__Chest Pain	__Shortness of Breath	__Buzzing in Ears
__Neck Stiff	__Dizziness	__Fatigue	__Loss of Balance
__Sleeping Problems	__Head seems to heavy	__Depression	__Loss of Smell
__Back Pain	__Pins & Needles in Arms	__Lights Bother Eyes	__Fainting
__Nervousness	__Pins & Needles in Legs	__Loss of Memory	__Loss of Taste
__Tension	__Numbness in Fingers	__Ears Ring	__Diarrhea
__Feet Cold	__Hands Cold	__Stomach Upset	__Constipation
__Fever	__Other		

Symptoms other than above _____

_____

Have you Lost Any Days off Work? ___Yes___No If Yes What Dates _____

Insurance Companies Involved:

My Company _____

Company of Person Responsible for Injuries _____

Have you been contacted by an Insurance Adjuster or Company representative regarding this claim? __ Yes __ No

Do you have an Attorney that has advised you in this case: ___Yes ___No

Attorney's
Name _____Address _____Telephone _____

Richard De Carlo
Doctor of Chiropractic

CASE HISTORY

DATE_____

NAME_____

ADDRESS _____CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____SOCIAL SECURITY NO. _____

HOME PHONE_____WORK PHONE_____MARITAL STATUS_____

SPOUSE'S NAME _____

CHILDREN'S NAMES AND AGES _____

_____

NAME OF EMPLOYER _____OCCUPATION _____

HOW LONG EMPLOYED _____WHO REFERRED YOU _____

_____

PLEASE DESCRIBE YOUR MAJOR COMPLAINTS AND SYMPTOMS _____

_____

_____

WERE THEY CAUSED BY A STRAIN? _____ STRESS? _____ FALL? _____ OVERUSE? _____

EXERCISE? _____ WORK RELATED? _____ AUTO ACCIDENT? _____ UNKNOWN? _____

WHEN DID THIS OCCUR? _____REOCCURRING CONDITION? _____

ANY FAMILY HISTORY OF THIS CONDITION?_____

HAVE YOU BEEN TREATED BY ANOTHER DOCTOR FOR THIS CONDITION? _____

M.D. _____ D.O. _____ D.C. _____ NAME OF DOCTOR _____

DIAGNOSIS _____TREATMENT _____

WERE X-RAYS TAKEN? _____WHEN? _____LENGTH OF TIME UNDER HIS/HER CARE?_____

RESULTS _____

_____

WHAT ACCIDENTS/FRACTURES HAVE YOU HAD? (INCLUDE DATES)_____

_____

WHAT MAJOR SURGERY HAVE YOU HAD? (INCLUDE DATES) _____

_____

LIST ANY MEDICATIONS YOU ARE PRESENTLY TAKING _____

WITHIN THE LAST 6 MONTHS? _____

_____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect a thorough diagnosis, treatment plan and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Appendicitis
- ☐ Scarlet Fever
- ☐ Diptheria
- ☐ Typhoid Fever
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Malaria
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Goiter
- ☐ Influenza
- ☐ Pleurisy
- ☐ Alcoholism
- ☐ Venereal Infection
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorder
- ☐ Eczema
- ☐ Stroke or family history of

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Swollen Joints/Stiffness
- ☐ Walking Problems
- ☐ Difficulty Chewing
- ☐ Clicking Jaw

NERVOUS SYSTEM

- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities

GASTRO-INTESTINAL

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Trouble
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY

- ☐ Painful/Excessive Urination
- ☐ Discolored Urine
- ☐ Inability to Control Urination

C-V-R

- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Cardiovascular Disease
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ High/Low Blood Pressure
- ☐ Chronic Coughing
- ☐ Difficulty Breathing
- ☐ Asthma
- ☐ Chronic Congestion

EENT

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE / FEMALE

- ☐ Taking Oral Contraceptives
- ☐ Previous Miscarriage
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain/Infections
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Genital Herpes
- ☐ Are You Pregnant? ☐ No ☐ Yes ☐ Maybe
- ☐ When Was Your Last Period? _____

GENERAL

- ☐ Allergies
- ☐ Sinus Problems
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Bruises Easily

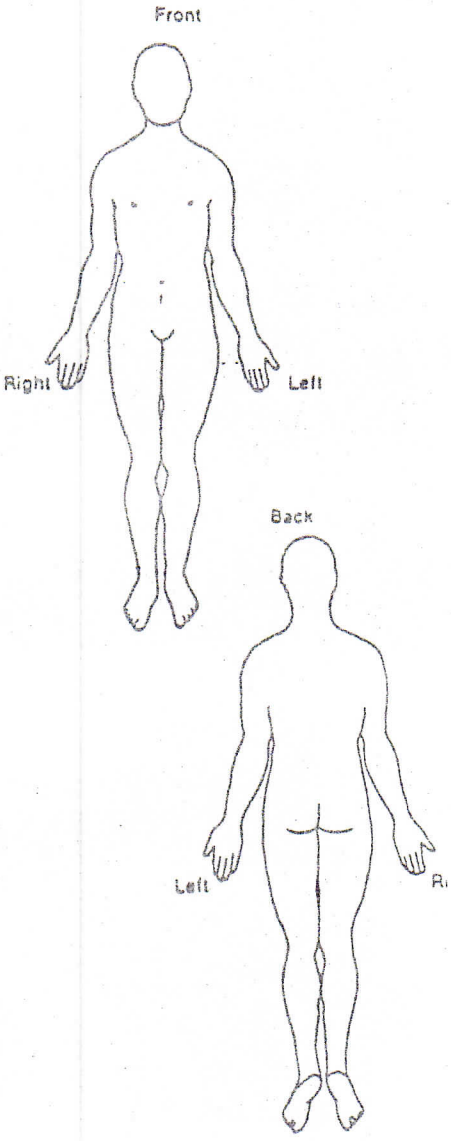
Patient's Signature _____

Doctor's Signature _____

Mark the areas on your body where you feel the described sensations. Use the appropriate symbols.

Ache | Burning | Numbness

Pins and Needles | Stabbing | Other



NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE

NAME _____ DATE _____

For any YES answer, please notify the Doctor:

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment: _____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment: _____
3. Do your hands or arms fall asleep regularly? NO YES
   Comment: _____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: _____
5. Do you suffer from a loss of hand grip strength? NO YES
   Comment: _____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: _____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: _____
8. Do our legs or feet fall asleep regularly? NO YES
   Comment: _____
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Comment: _____
10. Do you suffer from cold hands or feet? NO YES
    Comment: _____
11. Do you suffer from headaches, dizziness or memory loss? NO YES
    Comment: _____
12. Do you have difficulty maintaining your balance? NO YES
    Comment: _____
13. Do you suffer from vertigo or blurred vision? NO YES
    Comment: _____
14. Do you suffer from a reduced hearing capacity? NO YES
    Comment: _____
15. Do you suffer from ringing in your ears? NO YES
    Comment: _____
16. Do you haye bladder or bowel control problems on a regular basis? NO YES
    Comment: _____

DR. RICHARD DE CARLO

DOCTOR OF CHIROPRACTIC

▼ ▼ ▼

Please take a moment to fill out the following brief survey

How did you hear about our office?
(Please check one)

_____Referral

_____Insurance Company Provider Book

_____Billboard Sign

_____Shopping Center Sign

_____Health Fair/Screening

If this is a Referral, who referred you to our office?

_____

Have you ever had Chiropractic Care_____

Thank you for taking the time to fill out this very important Clinic survey

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E-mail: dr.decarlo@mindspring.com • Web Site: www.rickdecarlo.com

For your scheduling convenience, we are requesting e-mail addresses or text messaging numbers from our established patients. Please fill out this sheet if you would prefer to be contacted this way.

☐ I prefer to be e-mailed for my appointments.

My e-mail address is: _____

☐ I prefer to be texted for my appointments.

A good number to text me is:_____

☐ I prefer to just be called for my appointments.