Atlanta Chiropractic Injury Center

CONFIDENTIAL PATIENT INFORMATION

Name _____ Home Phone _____ Cell

Address _____City _____ Zip Code

Birth Date _____/_ _____/_____. Marital Status (M) (S) (W) (D) How Many Children

Occupation _____Employer

Employer Address _____Work Phone

Name of Spouse _____Spouses Occupation

Spouses Employer _____ Address

Date of Injury _____Time _____ Location _____County

Insurance Companies Involved My Auto Insurance

Insurance Responsible for Injuries

how did the accident happen

If auto collision, Were you struck? Behind _____ Passenger Side _____ Driver Side _____ Front

Have you had same or similar injuries before? (Y) (N) When

Past Illnesses or Unusual Diseases _____ When

Have you been treated for any health condition in the past year? (Y) (N) Describe

List nearest relative NOT living with you: Name _____ Phone

Address of relative

Other doctors seen for this condition

Have you missed any days of work? (Y) (N) Dates

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT/INJURY

Headaches	**Loss of Memory**	**Depression**	**Dizziness**	**Fever**
Neck pain	**Head seems heavy**	**Light Bothers Eyes**	**Feet Cold**	**Irritability**
Neck Stiff	**Pins and Needles in Legs**	**Pins and Needles in Arms**	**Hands Cold**	**Constipation**
Sleeping Problems	**Numbness in Fingers**	**Buzzing/Ringing in Ears**	**Cold Sweats**	**Face Flushed**
Back Pain	**Numbness in Toes**	**Fainting**	**Chest Pains**	**Loss of Balance**
Nervousness	**Shortness of Breath**	**Loss of Smell**	**Diarrhea**	
Stomach Upset	**Fatigue**	**Loss of Taste**	**Tension**	

Symptoms other than above

What Medications/Vitamin supplements are you taking?

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. If insurance coverage is available, benefits will be paid directly to the Clinic/Doctor.

Patient's Signature _____ S.S.#: _____ Date

Guardian/Parents Signature _____ Date

Information Taken by: _____ Date