HEALING TOUCH CHIROPRACTIC OF BOULDER, PLLC
Dr. Joanie De Bever
3005 47th St., Suite F-2, Boulder, CO. 80301 (303) 447-0036

"If you don't take care of yourself today, someone else may have to take care of you tomorrow!"

WELCOME, and thank you for choosing Healing Touch Chiropractic. In order to provide you with the best chiropractic care possible, please complete BOTH sides of this form. All information is CONFIDENTIAL and required for your care.

NAME:_____DATE:_____

ADDRESS:_____EMAIL:_____

CITY:_____STATE:_____ ZIP: _____ BIRTHDAY:_____

CHECK BEST CONTACT # □ HOME:_____ □ WORK/CELL:_____

SOCIAL SECURITY#:_____ OCCUPATION:_____

EMPLOYER:_____ADDRESS:_____

MARITAL STATUS:_____SPOUSE/PARTNER'S NAME:_____

THEIR OCCUPATION:_____EMPLOYER:_____

EMERGENCY CONTACT:_____TELEPHONE: _____

MAY WE CONTACT YOU THROUGH EMAIL? (WE NEVER SHARE OR GIVE OUT YOUR INFO)_____

WHO MAY WE THANK FOR REFERRING YOU?_____

PRESENT COMPLAINTS

IS YOUR VISIT DUE TO AN ACCIDENT? _____ NO (SKIP TO #1) _____ **IF YES: DATE OF INJURY**:_____

TYPE OF ACCIDENT:_____***AUTOMOBILE _____WORK-RELATED _____OTHER _____

(Describe)_____

*****IF THIS IS AN AUTO ACCIDENT, INSURANCE COMPANY:**_____Phone#:_____

Claim#:_____ Billing Address:_____

Name of the Insured:_____ Contact/Claim Agent: _____

1) HAVE YOU EVER HAD CHIROPRACTIC CARE _____NO _____YES; FOR? _____
2) DESCRIBE ***TODAY'S*** SYMPTOMS, ***LOCATION AND TYPE***_____

_____

3) LIST OTHER PROFESSIONALS SEEN FOR THIS CONDITION_____
4) HAVE YOU HAD TREATMENT FOR ANY HEALTH CONDITION IN THE LAST YEAR? NO _____ YES _____

*** DESCRIBE CONDITION(S)_____

5) DATE OF LAST PHYSICAL EXAM_____ MEDICATIONS CURRENTLY TAKING?_____
6) FOR WHAT CONDITION(S)?_____
7) ANY PREVIOUS SIGNIFICANT TRAUMAS/ ACCIDENTS? _____
8) DESCRIBE GOALS YOU HAVE FOR OBTAINING CARE: _____

_____

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NAME: _____ **TODAY'S DATE:** _____

NOTE: Please describe your symptoms **IN ORDER** OF **SEVERITY** and be **VERY SPECIFIC** in your answers. For the "**INTENSITY**", please use the number scale below **where 0=no symptoms and 10= worst ever experienced.**

NO SYMPTOMS	MILD	MODERATE	SEVERE
0	1—3	4—6	7—10

#1 WORST COMPLAINT: (EACH "COMPLAINT" IS A BODY PART OR AREA **)**
(DESCRIBE)_____
_____
*Frequency? (How often? Constant? Intermittent?)_____
*Intensity (0 – 10 see above) _____
*Does it stay local? Or refer (move around and to where?)_____
*Feels like? (numb, stiff, achy, sharp, tingles)_____
*What makes it feel better? _____
*What makes it feel worse?_____

#2 COMPLAINT
(DESCRIBE)_____
_____
*Frequency?_____
*Intensity? (0—10)_____
*Localized or refers? _____
*Feels like? _____
*What makes it feel better?_____
*What makes if feel worse?_____

#3 COMPLAINT
(DESCRIBE)_____
_____
*Frequency?_____
*Intensity?(0 – 10)_____
*Localized or refers? _____
*Feels like? _____
*What makes it better?_____
*What makes it worse?_____

HAVE YOU EVER HAD A PREVIOUS motor vehicle accident? ☐ no ☐ yes Dates?_____
HAVE YOU EVER HAD these symptoms prior to this accident? ☐ no ☐ yes If yes, please explain below

_____
_____

"OPTIMIZING LIFE EXPRESSION ONE SPINE AT A TIME!"

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CONFIDENTIAL MOTOR VEHICLE COLLISION QUESTIONNAIRE

Name: _____ Today's Date: _____ Injury Date: _____

Describe the accident in detail:
_____
_____
_____
_____

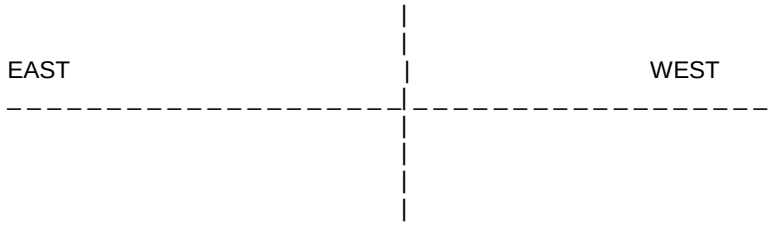
Road conditions were: ☐ Dry ☐ Wet ☐ Icy ☐ Gravel/dirt ☐ Other _____

YOUR VEHICLE TYPE: ☐ subcompact ☐ compact ☐ mid size ☐ SUV ☐ ¾ ton pick up ☐ other: _____
Your estimated speed: _____mph, and ☐ speeding up ☐ Slowing down ☐ Steady ☐ Stopped

OTHER VEHICLE TYPE: ☐ subcompact ☐ compact ☐ mid size ☐ SUV ☐ ¾ ton pick up ☐ other: _____
Other's estimated speed: _____ mph, and ☐ speeding up ☐ Slowing down ☐ Steady ☐ Stopped

Where were you seated? ☐ Driver ☐ Front passenger ☐ Right rear passenger ☐ Left rear passenger and sitting left/center/right.
Were you wearing a seat belt? ☐ No ☐ Yes ☐ Lap belt only ☐ Shoulder and lap belt
How was the top of the headrest positioned? ☐ Even with my head ☐ Middle of my head ☐ Base of my skull ☐ Unknown
Upon impact did you strike the headrest? ☐No ☐ Yes ☐ Unknown
Did your head extend over the top of the headrest? ☐ No ☐ Yes ☐ Unknown
Which way was your head pointed? ☐ Forward ☐ Turned right ☐ Turned left ☐ Looking down ☐ Unknown
Which way was your car pointed? ☐ Forward ☐ Turned right ☐ Turned left ☐ Unknown
Where you braced for the collision? ☐ No ☐ Yes ☐ Caught by surprise
Was your foot on the brake? ☐ No ☐ Yes ☐ Unknown
Was your vehicle struck from: ☐ Rear end (and *left or right*) ☐ Front end (and *left or right*) ☐ Side (and *left or right*)

Draw the angle of collision and placement of all vehicles:



What parts of your body hit what parts of your vehicle?
☐Unknown
☐ Head hit (describe) _____
☐ Chest hit (describe)_____
☐ Arm (L) (R) _____
☐ Leg (L) (R) _____
☐ Knee (L) (R) _____
Any cuts? ☐ No ☐ Yes (where?)_____
Bruising or swellings? ☐ No ☐Yes (where?) _____
Did you loose consciousness? ☐ No ☐ Yes (for how long?) Minutes_____ Hours _____ Days_____
Were police at the scene? ☐ No ☐ Yes Emergency paramedics? ☐ No ☐Yes
Were you examined at the scene? ☐ No ☐ Yes (by who?) _____
Did you receive emergency care at the scene? ☐ No ☐ Yes: describe treatment/MEDICATION? _____
_____

Were you taken to the hospital? ☐No ☐ Yes :by? Ambulance / Private car /Self Hospital name: _____
Were you examined in ER? ☐No ☐Yes
Xrays taken? ☐ No ☐Yes (areas): ☐ neck ☐ upper back ☐ low back ☐ other _____

Released: ☐ Same day ☐Other : _____ date (day/month/yr)_____

First treatment date AFTER your accident? (day/month/yr) _____ By?._____

Please review your answers for accuracy and provide as much detail as you can recall so we may accurately provide care.

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NAME: _____ **TODAY'S DATE:** _____

CLAIM#: _____ **DATE OF ACCIDENT:** _____

COGNITIVE SYMPTOM QUESTIONNAIRE

	NO	YES
1. Have you recently been involved in any type of accident/injury in which you hit your head	____	____
2. Have you recently experienced a whiplash injury?	____	____
3. Are you currently experiencing any memory difficulties?	____	____
4. Are you experiencing any attention or concentration difficulties?	____	____
5. Are you able to express yourself as well as you always could?	____	____
6. Do you now experience difficulties planning or organizing your daily life?	____	____
7. Are you able to solve problems as efficiently as you always could?	____	____
8. Do you now become confused or make mistakes about where you are?	____	____
9. Do you now have more difficulty in calculating or working with numbers?	____	____
10. Are you experiencing any visual difficulties?	____	____
11. Are you now feeling more emotional than prior to your injury?	____	____
12. Do you believe you are depressed?	____	____