Flamingo Neck & Back

Intake Form for MVA
3585 E. Flamingo Road Ste. 202
Las Vegas, NV 89121

(Please print or circle where indicated) Today's Date:_____

Last Name: _____First Name: _____Middle Initial: _____

Policy or Social Security #:_____ Date of Birth: ____/____/_____ Gender: M F

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( )_____-_____ Cell Phone: ( )_____-_____ Work Phone: ( )_____-_____

Indicate which number is best to reach you: Home Cell Work

Email Address: _____ May we contact you by email? Y N

Occupation: _____ Employer: _____

Do you work: Full-time Part-time Retired N/A ?

Marital Status: M S W D If Married, Spouse's Name: _____

Have you ever had chiropractic treatment? Yes No If so, date of last treatment: _____

Car Insurance or Attorney Information

Insurance Company: _____ Claim Number: _____

Adjustor Name: _____ Phone Number: _____

Attorney Name: _____ Phone Number: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Who can we thank for referring you to our office?

Name: Mr./Ms./Dr._____ Clinic: _____

Family History

	Back	Heart	Stroke	Cancer	Diabetes	High Blood Pressure	Arthritis	High Cholesterol	Osteoporosis	Thyroid
Mother										
Father										
# of Sisters ____										
# of Brothers ____										
# of Children ____										

Social History

Height: _____ Weight: _____

Do you?	Daily	3x/week	2x/week	1x/week	2x/month	1x/month	Never
Use Tobacco/Smoke							
Exercise							
Work at Computer							
Sit at a Desk							
Work on a Phone							
Alcoholic Drinks							
Moderate/Heavy Labor							
Stay at Home							
Deliver Packages							

Medical History

Serious Illness: Please circle any condition for which you have ever received examination or treatment.

Alcohol/Drug Addiction	Anemia	Arrhythmia	Arthritis
Asthma	Backaches	Bleeding Disorder	Blood Clots
Blood Transfusions	Blurred Vision	Bowel Problems	Broken Bones
Cancer	Carpal Tunnel	Cataracts	Chicken Pox
Colitis	Collagen Vascular Disease	Constipation	Depression/Anxiety
Diabetes	Digestive Disorders	Dizziness	Eating Disorder
Emphysema	Epilepsy	Fatigue	Female Health Challenges
Gallbladder Disease	Genital Herpes	Glaucoma	Gluten Intolerance
Gout	Headaches	Hearing Loss	Heart Disease/Attacks
Heart Murmur	Hemorrhoids	Hepatitis	High Blood Pressure
High Cholesterol	HIV/AIDS	Joint/Back Pain	Kidney Infections
Kidney Stones	Liver Disease/Problems	Lung Disease	Menstrual Cramps
Mental Disorder	Migraines	Neck Pain	Nervousness
Night Sweats	Osteoporosis	Paralysis	Pneumonia
Polio	Prostate Problems	Reflux/Ulcers	Rheumatic Fever
Seizures/Epilepsy	Sexual Dysfunction	Sickle Cell	Sinus Trouble
Stress/Tension	Stroke	Suicidal Tendencies	Thyroid Disease
Tuberculosis	Tumors	Urine Discoloration	Vertigo

Surgical History **PLEASE DO NOT EXCLUDE ANY**

Surgery Name	**Date Performed (Year)**

Allergies

Allergy Name	Date Detected

Current Medications

Name of Medication	Reason for Taking Medication

Accident History

Enter all auto accidents, slips & falls, sports or work related injuries that you have had in the past

Accident Type	Date	Chiropractic Treatment Received
☐ Auto ☐ Sports Related ☐ Work Related ☐ Major Slip & Fall		Yes No
☐ Auto ☐ Sports Related ☐ Work Related ☐ Major Slip & Fall		Yes No
☐ Auto ☐ Sports Related ☐ Work Related ☐ Major Slip & Fall		Yes No
☐ Auto ☐ Sports Related ☐ Work Related ☐ Major Slip & Fall		Yes No
☐ Auto ☐ Sports Related ☐ Work Related ☐ Major Slip & Fall		Yes No
☐ Auto ☐ Sports Related ☐ Work Related ☐ Major Slip & Fall		Yes No

AUTO ACCIDENT HISTORY

Date of Accident _____ Time of Accident _____ AM/PM

Your vehicle: Make _____ Model _____ Year_____

Other vehicle: Make _____ Model _____ Year_____

You were the: Driver Front seat passenger

Rear seat passenger Left-Side Middle Right-Side

What was the speed of your vehicle? _____ m.p.h.

Was it Daylight Night Sunrise Sunset ?

What was your visibility? Excellent Reduced

Were the brakes applied? Yes No

Type of road? 2-Lane 4-Lane Gravel Tar

Road conditions: Slippery Wet Dry Damp Muddy Sandy

Did it happen at: Traffic Light Stop Sign Intersection Highway ?

Was your car hit: Front Back Left-Side Right-Side ?

Where was the other car hit: Front Back Left-Side Right-Side ?

Damage to your car: $_____ Damage to the other car $_____

Did the air bag deploy? Yes No

Was a police report filed? Yes No

During the collision, did you hit any part of your body? Yes No

If yes, describe which part and how. For example, Hit head on dash, or chest on steering wheel.

_____

What was the position of your head and neck prior to impact?

Up Down Level Straight Left Right

Were you reclined? Yes No

Lap belt on? Yes No Shoulder harness on? Yes No

Were you aware of the impending crash? Yes No

Position of the headrest: Low High Improperly Adjusted

Were you conscious after the accident? Yes No

Did you receive emergency care at the scene? Yes No

Were you hospitalized? Yes No

If Yes, at which facility and for how long? _____

Describe any additional details about the accident: _____

_____

_____

_____

_____

Accident Diagram: Please draw the vehicles (noting direction traveled and areas of damage)

Current Complaints

What is your FIRST complaint? _____ LEFT RIGHT BOTH N/A

Did the problem start GRADUALLY SUDDENLY OVER TIME ?

Is the problem MILD MODERATE SEVERE ?

Choose one way to describe your pain: ACHING BURNING CRAMPING NUMB PINCHING
POUNDING RADIATING SHARP SHOOTING SORE STIFF STINGING
THROBBING TIGHT TINGLING

Please rate your pain today on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

0 1 2 3 4 5 6 7 8 9 10

Date when symptom first appeared, if known: _____

Frequency: CONSTANT FREQUENT INTERMITTENT OCCASIONAL

What caused the complaint? _____

What makes the problem better? _____ Worse? _____

Problem worse during: MORNING AFTERNOON EVENING NIGHT

Do you experience numbness or tingling? YES NO If yes, where? _____

Does the pain radiate? YES NO If yes, where? _____

What is your SECOND complaint? _____ LEFT RIGHT BOTH N/A

Did the problem start GRADUALLY SUDDENLY OVER TIME ?

Is the problem MILD MODERATE SEVERE ?

Choose one way to describe your pain: ACHING BURNING CRAMPING NUMB PINCHING
POUNDING RADIATING SHARP SHOOTING SORE STIFF STINGING
THROBBING TIGHT TINGLING

Please rate your pain today on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

0 1 2 3 4 5 6 7 8 9 10

Date when symptom first appeared, if known: _____

Frequency: CONSTANT FREQUENT INTERMITTENT OCCASIONAL

What caused the complaint? _____

What makes the problem better? _____ Worse? _____

Problem worse during: MORNING AFTERNOON EVENING NIGHT

Do you experience numbness or tingling? YES NO If yes, where? _____

Does the pain radiate? YES NO If yes, where? _____

What is your THIRD complaint? _____ LEFT RIGHT BOTH N/A

Did the problem start GRADUALLY SUDDENLY OVER TIME ?

Is the problem MILD MODERATE SEVERE ?

Choose one way to describe your pain: ACHING BURNING CRAMPING NUMB PINCHING

POUNDING RADIATING SHARP SHOOTING SORE STIFF STINGING

THROBBING TIGHT TINGLING

Please rate your pain today on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

0 1 2 3 4 5 6 7 8 9 10

Date when symptom first appeared, if known: _____

Frequency: CONSTANT FREQUENT INTERMITTENT OCCASIONAL

What caused the complaint? _____

What makes the problem better? _____ Worse? _____

Problem worse during: MORNING AFTERNOON EVENING NIGHT

Do you experience numbness or tingling? YES NO If yes, where? _____

Does the pain radiate? YES NO If yes, where? _____

What is your FOURTH complaint? _____ LEFT RIGHT BOTH N/A

Did the problem start GRADUALLY SUDDENLY OVER TIME ?

Is the problem MILD MODERATE SEVERE ?

Choose one way to describe your pain: ACHING BURNING CRAMPING NUMB PINCHING

POUNDING RADIATING SHARP SHOOTING SORE STIFF STINGING

THROBBING TIGHT TINGLING

Please rate your pain today on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

0 1 2 3 4 5 6 7 8 9 10

Date when symptom first appeared, if known: _____

Frequency: CONSTANT FREQUENT INTERMITTENT OCCASIONAL

What caused the complaint? _____

What makes the problem better? _____ Worse? _____

Problem worse during: MORNING AFTERNOON EVENING NIGHT

Do you experience numbness or tingling? YES NO If yes, where? _____

Does the pain radiate? YES NO If yes, where? _____