West Coast Wellness
Dr. Daniel Barr, D.C.
941-429-0070

New Patient Health History Form

In order to provide you with the best possible wellness care, please complete this form. All information is strictly confidential

Patient Data:

First Name:_____ **Last Name:**_____ **Date:**__/__/__
Address:_____ **City:**_____ **State:**_____ **Zip:**_____
Email Address:_____
Age:_____ **DOB**___/___/___ **Social Security #:**_____/_____/_____
Telephone # (home):_____ **(cell)**_____
Occupation:_____ **Employer:**_____
Marital Status:_____ **Spouse's Name:**_____
Emergency Contact Name:_____
Emergency Contact #:_____

Current Complaints :

Nature of Injury: ___**Automobile** ___**Work** ___**Other** **State accident occurred :** _____
Date of Injury___/___/___ **Date symptoms appeared**___/___/___
Have you ever had the same condition?___**Yes**___**No If yes, when?:**_____
Have you seen any other practitioners for this injury/condition?___**Yes**___**No If yes, when**_____
Have you ever been under chiropractic care before?___**Yes**___**No If yes, when**_____

Insurance Information:

*****If this is relative to an auto accident:**
Name of auto insurance company:_____ **Insurance adjuster name:**_____
Claim #:_____ **Telephone#:**_____
*****Attorney information:**
Name of Law Firm:_____ **Attorneys name:**_____
Contact person:_____ **Telephone#:**_____
*****Health Insurance Information:**
Name of Health Insurance Company:_____ **Member#:**_____

Signature:

I understand that all auto or health insurance policies are an arrangement or agreement between myself and the insurance carrier. I further accept and agree to be personally liable for the timely payment of any balance left unpaid by any insurance carrier. I further understand that if I suspend or terminate my care/treatment with West Coast Wellness, any fees for professional services rendered to me, will be immediately due and payable. Further, if for any reason, any legal action is necessary to collect any unpaid balances incurred by me for medical treatment with West Coast Wellness, I agree to be responsible for all court costs and reasonable attorney's fees incurred for the enforcement of this agreement.

*Patient/Guardian Signature:*_____ *Date:*___/___/___

Patient Medical Information

Medical Conditions: (Check all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Thyroid	CAD/CHF/ Arrhythmia	CVA/TIA/Migraines	PUD/IBSGerd
Kidney Stones/UTI's	**TB/HEP/HIV**		
Other_____			

Past Surgical History (Check all that apply to you)

Appendectomy	Cardiovascular Procedure	Cervical Spine	Hysterectomy
Orthopedic	Prostate	Lumbar Spine	Gall Bladder
Brain	Shoulder	Thoracic Spine	Knee
Carpal Tunnel	Gastrointestinal	Uri-genital	Hernia
Pacemaker/Difib			

Allergies: (Check all that apply to you)

Eggs	Fish and Shellfish	Milk or Lactose	Peanuts
Soy	Sulfates	Wheat/Glutens	Other_____

Social History: (Check all that apply to you)

Caffeine use:	Occasional	Often	Never
Alcohol Use:	Occasional	Often	Never
Exercise:	Occasional	Often	Never
Tobacco Use:	Occasional	Often	Never
Wear Seat Belts:	Occasional	Often	Never
Other_____			

Family History: (Check all that apply to you)

HIV/HEP	Parent	Sibling
TB	Parent	Sibling
Arthritis:	Parent	Sibling
Cancer :	Parent	Sibling
Diabetes:	Parent	Sibling
Heart Disease:	Parent	Sibling
Hypertension:	Parent	Sibling
Stroke:	Parent	Sibling
Thyroid:	Parent	Sibling
Other:	_____	

Please list ALL medications you are currently taking

Personal Injury Questionnaire

In your own words, please describe where and how this accident happened.

_____

_____

_____

_____

_____

_____

Did you go to the hospital? ____Yes____No
Where you admitted to the hospital? ____Yes____No
If you went to the hospital, When?____At the time of the accident____Next day
How did you get to the hospital? ____Ambulance____Private transportation____Other
Name of Hospital: _____
Attending Doctor: _____
What treatment was given?

____None ____Placed in a cervical collar ____X-Rays ____Given stitches ____Bandaged

____Given pain medication ____CT scans ____Given instructions regarding sprains and strains

____Given instructions regarding concussions ____Instructed to call an Orthopedic Surgeon

____Instructed to call a private physician

Personal Injury Questionnaire

1.)Patients Vehicle Type:

a. Sports Car
b. Coupe
c. Sedan
d. Sports Utility Vehicle
e. Station Wagon
f. Pick-Up Truck

2.)Place the patient was seated in the vehicle:

a. Driver
b. Front Seat passenger
c. Back Seat Passenger(Driver side)
d. Back Seat Passenger(Right side)
e. Back Seat Passenger (Middle)
f. Other: _____

3.)Vehicle Size:

a. Compact
b. Mid-Sized
c. Full-Sized

4.) Actions of the patients vehicle:

a. Crossing an intersection
b. Stopped at an intersection
c. Stopped for a pedestrian
d. Stopped for traffic
e. Traveling at posted speed limit
f. Traveling faster than posted speed
g. Turning

5.)How was the patients vehicle hit:

a. Hit head-on
b. Hit on the left front
c. Hit on the right front
d.Hit on the left rear
e. Hit on the right rear
f. Rear-ended

6.)Damage to the patients vehicle:

a. Complete
b. Extensive
c .Minimal
d. Moderate

7.)Describe the second vehicle:

a. Compact
b. Full-Sized
c. Mid-Sized
d. Semi-Trailer
e. Pick Up Truck

8.)Weather Conditions:

a. Clear
b. Cloudy
c. Drizzling
d. Foggy
e. Rainy
f. Snowy
g. Stormy
h. Sunny

9.)Road Conditions:

a. Damp
b. Dry
c. Iced Over
d. Snowed Over

10.)Body position at the time of impact:

a. Leaning forward
b. Slouched down in the seat
c. Straight
d. Turned to the left
e. Turned to the right

11.) Direction body was thrown:

a. Backward then forward
b. Forward then backward
c. To the left
d. To the right
e. About the vehicle
f. Outside the vehicle
g. Under the vehicle

12.) Head position at impact

a. Straight
b. Tilted forward
c. Turned to the left
d. Turned to the right

13.) Direction head was thrown

a. Backward then forward
b. Forward then backward
c. Side to side

14.) Did the air bags deploy

(___)Yes(___)No

15.) Did you anticipate the accident?

(___)Yes(___)No

16.) Did you lose consciousness?

(___)Yes(___)No

17.) Did you strike anything in the vehicle?

(___)Yes(___)No

Symptoms

18.) Do you have any Lacerations, Cuts or Bruising?

a. Head or face
b. Neck
c. Seat belt bruising
d. Cuts or bruising on your chest
e. Cuts or bruising on your arms
f. Cuts or bruising on your legs
g. Other:_____
_____

19.) Jaw Symptoms

a. Jaw Pain (___)Yes(___)No
b. Clicking
c. Pain while chewing
d. Pain while talking
e. Pain while yawning
f. Pain while moving jaw side to side

20.) Head Injuries (Now or at the time of the accident)

a. Headaches
b. Face Pain
c. Different sized pupils
d. Dizziness
e. Difficulty walking
f. Balance problems
g. Disoriented/ confusion
h. Attention problems.
I. Hearing problems
j. Change in sense of smell or taste
k. Difficulty speaking
l. Memory problems.
m. Tiredness or fatigued
n. Appetite change
o. Sleep difficulties
p. Blurred vision
q. Problems reading or writing
r. Problems adding or subtracting
s. Problems learning new things
t. Problems understanding
u. Difficulty concentrating
v. Change in sexual function
w. Nausea/ Vomiting
y. Change in personally
z. Flashbacks to the accident
aa. Wanting to be alone
bb. Mood swings
cc. Sadness
dd. Agitation
ee. Anger
ff. Irritability
gg. Impatience
hh. Other _____

Symptoms

1)Neck Symptoms

a. Neck Pain (___)Yes(___)No

b. Neck pain with numbness, tingling or weakness that radiates or goes down the RIGHT shoulder, arm, forearm or hand. (___)Yes(___)No

c. Neck pain with numbness, tingling or weakness that radiates or goes down LEFT shoulder, arm, forearm or hand.(___)Yes(___)No

d. Neck pain with numbness, tingling or weakness that radiates down into the RIGHT UPPER BACK. (___)Yes(___)No

e. Neck pain with numbness, tingling or weakness that radiates down into the LEFT UPPER BACK.(___)Yes(___)No

f. Neck pain that causes headaches. (___)Yes(___)No
g. Neck pain that causes spasms. (___)Yes(___)No

h. Popping, clicking or clunking sound with movement of the neck. (___)Yes(___)No

2.)Shoulder Symptoms

a. Shoulder Pain (___)Left(___)Right
b. Location of pain. LEFT____RIGHT___
c. Shoulder pain with Movement.(___)Yes(___)No
   d. Sharp or shooting pain
   di. Dull Pain
   dii. Achy Pain .

3)Upper Arm Symptoms

a. Upper arm pain(___)Left(___)Right
   ai. Dull Pain
   aii. Achy Pain
   aiii. Sharp or Shooting Pain

4.) Elbow Symptoms

a. Elbow pain(___)Left(___)Right
   ai. Sharp or Shooting Pain
   aii. Dull
   aiii. Achy Pain

5)Forearm Symptoms

a. Forearm Pain (___)Left(___)Right
   ai. Dull
   aii.Sharp or Shooting Pain
   aiii. Achy Pain

6.) Wrist Symptoms

a. Wrist Pain(___)Left(___)Right
   ai. Dull
   aii. Achy
   aiii. Sharp or Shooting

7.) Hand Symptoms

a. Hand Pain (___)Left(___)Right
   ai. Dull
   aii. Achy
   aiii. Sharp or Shooting

8.)Chest Symptoms

a. Chest Pain (___)Yes(___)No

9.)Stomach Symptoms

a. Stomach Pain (___)Yes(___)No

Other Symptoms

_____

_____

_____

_____

_____

_____

_____

_____

_____

Symptoms

10.) Mid & Upper Back Symptoms

a. Upper or Mid back pain(___)Yes(___)No

b. Upper or Mid back pain, numbness or tingling that radiates into the RIGHT shoulder.(___)Yes(___)No

c. Upper or Mid back pain, numbness or tingling that radiates into the LEFT shoulder (___)Yes(___)No

d. Upper or Mid back pain that causes spasms(__)Yes(___)No

11.)Low Back Symptoms

a. Low Back Pain(___)Yes(___)No

b. Low back pain with numbness or tingling that radiates down into the RIGHT buttock, thigh, leg or foot. (___)Yes(___)No

c. Low back pain with numbness or tingling that radiates down into LEFT buttock, thigh, leg or foot.(___)Yes(___)No

d. Low back pain that causes spasms. (___)Yes(___)No

12.)Pelvic or Sacral Symptoms

a. Pelvic or Sacral pain with numbness, tingling or weakness that goes into RIGHT buttock, thigh, leg or foot. (___)Yes(___)No

b. Pelvic or Sacral pain with numbness, tingling or weakness that goes into LEFT buttock, thigh, leg or foot. (___)Yes(___)No

13.)Hip Symptoms

a. Hip Pain (___)Yes(___)No

b. Hip pain with numbness, tingling or weakness that goes into buttock, thigh, leg or foot. (___)Yes(___)No

14.) Upper Leg Symptoms

a. Upper leg/Thigh Pain (___)Left(___)Right

b. Upper Leg/Thigh Pain that radiates down into RIGHT Knee (___)Yes(___)No

c. Upper Leg/Thigh pain that radiates down into Left Knee (___)Yes(___)No

15.) Knee Symptoms

a. Knee Pain (___)Left(___)Right

b. Knee pain that radiates into the calf (___)Yes(___)No

c. Knee pain that radiates into the ankle or foot(___)Yes(___)No

16.) Ankle Symptoms

a. Ankle Pain (___)Left(___)Right

b. Which Ankle. Left____Right____

17.) Foot Symptoms

a. Foot Pain (___)Left(___)Right
b. Which Foot. Left____Right____

Other Symptoms

_____

_____

_____

_____

_____

_____

_____

Notice: Patient Privacy

How Medical Information About You May Be Used and Disclosed and How You Can Access This Information.

We are committed to protecting the privacy of your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996, we are required by law, to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide, and related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information and/or records for other purposes without your consent or authorization.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligation under the law. We may revise our notice from time to time. The effective date is the date signed and indicates the date of the most current notice in effect.

You have a right to receive a copy of our most current notice in effect. If you have not yet reserved a copy of our current notice, please ask the front desk and we will provide you with our most current copy.

If you have any questions, concerns or comments about the notice or your medical information, please contact our office at (941-429-0070)

_____ _____

Signature Date

_____

Printed patient name