Kenmore CHIROPRACTIC

POST COLLISION INFORMATION

Check all symptoms you had BEFORE and/or AFTER the accident, and/or right NOW:

B	A	N		B	A	N	
O	O	O	Headache	O	O	O	Dizziness
O	O	O	Neck Pain	O	O	O	Head seems too heavy
O	O	O	Neck Stiffness	O	O	O	Pain in Arm(s)
O	O	O	Sleep Disturbance	O	O	O	Pain in Leg(s)
O	O	O	Trouble falling asleep	O	O	O	Numbness in Finger(s)
O	O	O	Back Pain	O	O	O	Numbness in Toe(s)
O	O	O	Nervousness	O	O	O	Shortness of Breath
O	O	O	Pain between Shoulders	O	O	O	Chest Pain/Tightness
O	O	O	Irritability	O	O	O	Fatigue
O	O	O	Sensitivity to Light	O	O	O	Depression/Upset
O	O	O	Sensitivity to Sound	O	O	O	Loss of Memory
O	O	O	Ears Ringing/Buzzing	O	O	O	Cold Hands/Feet
O	O	O	Loss of Hearing	O	O	O	Face Flushed
O	O	O	Fainting	O	O	O	Fever/Cold Sweats
O	O	O	Loss of Balance	O	O	O	Diarrhea/ Constipation
O	O	O	Loss of Taste or Smell	O	O	O	Nausea
O	O	O	Other? _____	O	O	O	Other? _____

Were you taken to the hospital? YES or NO **Immediately after the accident?** YES or NO

Name of the Hospital: _____ **City:** _____ **State:**_____

How did you get to the Hospital? _____

Did you receive treatment? YES or NO (just examination) **If Yes, what?** _____

Did you receive X-Rays? YES or NO **Did you receive an MRI?** YES or NO

Have you been treated previously for any of these symptoms? _____

_____

Any previous accidents, hospitalizations, fractures?

Year? _____

Year? _____

Year? _____

Have you lost any days of work? YES or NO **How Many?** _____