**WHEELOCK CHIROPRACTIC**
**INJURY REPORT**

Name _____ Social Sec.# _____Home Phone _____

Address _____City _____ ST._____ Zip _____

Sex: M F Birth Date _____ Marital Status: M S D W Occupation _____

Employer _____ Work Phone _____

Employer Address _____ ST._____

Please explain in detail how your accident happened _____

_____

_____

_____

Have you retained an attorney? ____ Yes ____ No

Attorney's name and address _____

_____

What is the Time _____ AM or PM , and Date _____/_____/_____ of this injury? State?_____

Where did this injury occur? ____at work ____at home ____in car ____other (explain) _____

Did you feel pain immediately following the accident? ____ Yes ____ No

Doctor's name _____ ____D.C. ____M.D. ____D.O. ____D.D.S.

Diagnosis _____ Treatment _____

Frequency of visits _____ Duration of treatment _____

What have you done to relieve your symptoms? _____

Have you ever injured this area before? ____ Yes ____No When? _____

Before this injury were you able to work on an equal basis as others your age? ____ Yes ____ No

Since this injury are your symptoms ____ improving? ____getting worse? ____ the same?

***************WORKER'S COMPENSATION ACCIDENT INFORMATION ONLY***************

Name of W/C contact at work _____ Title _____

Did you report this injury to your employer? ____ Yes ____ No

Did you return to work? ____ Yes ____ No If so, days missed _____ through _____

Have you had Work Comp injuries before? ___ Yes ____ No If so, how many times? _____

Name of other doctors you have consulted for previous W/C injuries _____

Do previous injuries affect your employment? ____ Yes ____ No

Do you favor any part of your body when you work? ____ Yes ____ No Explain _____

**Turn to other side and continue**

**********AUTOMOBILE ACCIDENT INFORMATION ONLY**********

Driver of vehicle in which you were injured:_____Insured:_____
Auto Ins Co:_____Address:_____
Phone #:_____Policy#:_____Claim#_____
Driver of other vehicle(if applicable) Name:_____Insured:_____
Auto Ins Co:_____Address:_____
Phone #:_____Policy#:_____Claim#:_____
You were heading____North____South____East____West on_____(street/highway)
Other vehicle headed ____North____South____East____West on_____(street/highway)
You were struck from____behind____front____right side____left side
You were the ____driver____passenger____middle____front seat____back seat____using belts____air bags
Police notified? ____Yes____No Were you knocked unconscious? ____Yes____No How long? _____
Where treatment was given?_____

**PLEASE INDICATE ALL OF THE SYMPTOMS BELOW YOU ARE PRESENTLY EXPERIENCING**

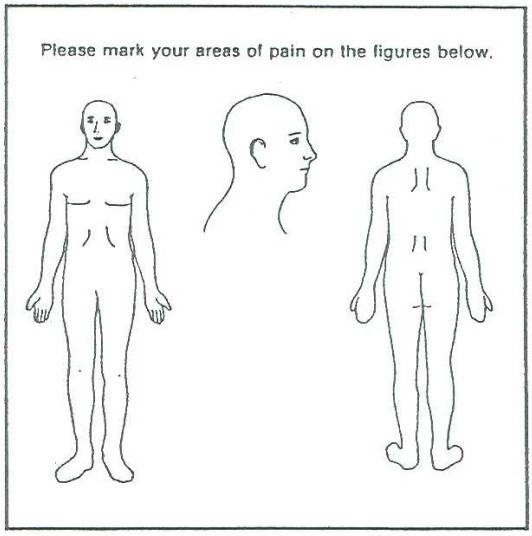
MUSCULO-SKELETAL SYSTEM
___Low back problems
___Pain between shoulders
___Neck problems
___Arm problems
___Leg problems
___Swollen joints
___Painful joints
___Stiff joints
___Sore muscles
___Weak muscles
___Walking problems
___Ruptures
___Broken Bones

GENITO-URINARY SYSTEM
___Bladder trouble
___Excessive urination
___Scanty urination
___Painful urination
___Discolored urine

FEMALE
___Vaginal discharged
___Vaginal bleeding
___Vaginal pain
___Breast pain
___Lumps on breast
Are you pregnant?
___Yes___No

GASTRO-INTESNIAL SYSTEM
___Poor appetite
___Excessive hunger
___Difficult chewing
___Difficult swallowing
___Excessive thirst
___Nausea
___Vomiting food
___Vomiting blood
___Abdominal pain
___Diarrhea
___Constipation
___Black stool
___Hemorrhoids
___Liver trouble
___Gall bladder problems
___Weight trouble

CARDIO-VASCULAR RESPIRATORY
___Chest pain
___Pain over heart
___Difficult breathing
___Persistent cough
___coughing phlegm
___Coughing blood
___Rapid heart beat
___Blood pressure problems
___Heart problems
___Lung problems
___Varicose veins




NERVOUS SYSTEM
___Numbness
___Loss of feeling
___Paralysis
___Dizziness
___Fainting
___Headaches
___Muscle jerking
___Convulsions
___Forgetfulness
___Confusion
___Depression

EYE, EAR, NOSE AND THROAT
___Eye strain
___Eye inflammation
___Vision problems
___Ear pain
___Ear noises
___Ear discharge
___Hearing loss
___Nose pain
___Nose bleeding
___Nose discharge
___Diff breathing thru nose
___Sore gums
___Dental problems
___Sore mouth
___Sore throat
___Hoarseness
___Difficult speech

_____ _____
PATIENTS SIGNATURE DATE