

# Southside Chiropractic

Dr. Jonathan Golub

(516) 783-3700

**NF**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

HOME PHONE #: \_\_\_\_\_ WORK #: \_\_\_\_\_ CELL: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_ # CHILDREN: \_\_\_\_\_

AUTO INSURANCE COMPANY: \_\_\_\_\_ CLAIM #: \_\_\_\_\_

RESPONSIBLE PARTY'S NAME (who the auto was owned and insured by): \_\_\_\_\_

ADDRESS (if different than your own): \_\_\_\_\_

ATTORNEY'S NAME & PHONE: \_\_\_\_\_

=====

## **NATURE OF ACCIDENT:**

1. Date of accident: \_\_\_\_\_ Time: \_\_\_\_\_ Weather Conditions: \_\_\_\_\_ Road Conditions: \_\_\_\_\_

2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat

3. Number of people in your vehicle: \_\_\_\_\_

4. Were you wearing safety belts? \_\_\_\_\_

5. Is the vehicle equipped with air bags? \_\_\_\_\_ If yes, did they deploy? \_\_\_\_\_

6. What direction were *you* headed? ( ) North ( ) South ( ) East ( ) West On (street name): \_\_\_\_\_

7. What direction was the *other vehicle* headed? ( ) North ( ) South ( ) East ( ) West On (street name): \_\_\_\_\_

8. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side

9. Approximate speed of your vehicle: \_\_\_\_\_ MPH Other vehicle: \_\_\_\_\_ MPH

10. Were you knocked unconscious? ( ) YES ( ) NO If yes, for how long? \_\_\_\_\_

11. Were the police notified? ( ) YES ( ) NO

12. In you own words, please describe the accident: \_\_\_\_\_

\_\_\_\_\_

13. Please describe how you felt:

BEFORE THE ACCIDENT: \_\_\_\_\_ IMMEDIATELY AFTER THE ACCIDENT: \_\_\_\_\_

WHAT ARE YOUR **CURRENT COMPLAINTS**?: \_\_\_\_\_

\_\_\_\_\_

**DOCTOR'S NOTES:**

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14. Where were you taken after the accident? \_\_\_\_\_ How did you get there? \_\_\_\_\_
15. Have you seen any other doctor/health care provider for this accident? \_\_\_\_\_
16. Since this accident, are your symptoms: ( ) Better ( ) The Same ( ) Worse
17. Have you been in any accidents *before*? ( ) YES ( ) NO If yes, please describe, including type, date, complaints and treatment:
- \_\_\_\_\_
- \_\_\_\_\_

### PLEASE CHECK ALL PROBLEMS & SYMPTOMS YOU EXPERIENCE

☐ HEADACHE  
☐ STIFF NECK  
☐ SLEEPING PROBLEMS  
☐ BACK PAIN  
☐ NERVOUSNESS  
☐ TENSION  
☐ IRRITABILITY  
☐ CHEST PAIN  
☐ SKIN CHANGES  
☐ DIZZINESS  
☐ PINS & NEEDLES IN ARMS  
☐ PINS & NEEDLES IN LEGS  
☐ NUMBNESS IN FINGERS  
☐ NUMBNESS IN TOES  
☐ SHORTNESS OF BREATH  
☐ FATIGUE  
☐ DEPRESSION  
☐ LIGHT BOTHERS EYES  
☐ EARS RINGING / BUZZING  
☐ LOSS OF BALANCE  
☐ FAINTING  
☐ LOSS OF SMELL / TASTE  
☐ DIARRHEA  
☐ UPSET STOMACH  
☐ CONSTIPATION  
☐ COLDS SWEATS  
☐ FEVER  
☐ ANY INFECTIOUS DISEASES  
☐ WE SHOULD KNOW ABOUT

#### DOCTOR'S NOTES

#### PAIN IN:

NECK L \_\_\_\_\_ R \_\_\_\_\_  
 SHOULDER L \_\_\_\_\_ R \_\_\_\_\_  
 ARM L \_\_\_\_\_ R \_\_\_\_\_  
 ELBOW L \_\_\_\_\_ R \_\_\_\_\_  
 HAND L \_\_\_\_\_ R \_\_\_\_\_  
 UPPER BACK L \_\_\_\_\_ R \_\_\_\_\_  
 MID BACK L \_\_\_\_\_ R \_\_\_\_\_  
 LOWER BACK L \_\_\_\_\_ R \_\_\_\_\_  
 HIP L \_\_\_\_\_ R \_\_\_\_\_  
 THIGH L \_\_\_\_\_ R \_\_\_\_\_  
 CALF L \_\_\_\_\_ R \_\_\_\_\_  
 KNEE L \_\_\_\_\_ R \_\_\_\_\_  
 ANKLE L \_\_\_\_\_ R \_\_\_\_\_  
 CHEST AREA L \_\_\_\_\_ R \_\_\_\_\_  
 ABOVE STOMACH \_\_\_\_\_  
 BELOW STOMACH \_\_\_\_\_  
 GALL BLADDER AREA \_\_\_\_\_  
 APPENDIX AREA \_\_\_\_\_  
 KIDNEY AREA \_\_\_\_\_  
 PAINFUL MENSES \_\_\_\_\_  
 PROSTATE PROBLEMS \_\_\_\_\_

OTHER: \_\_\_\_\_

ANYTHING ELSE THE DOCTOR SHOULD KNOW?

\_\_\_\_\_

\_\_\_\_\_

#### DOCTOR'S NOTES

If FEMALE, is there any chance you are PREGNANT?

\_\_\_\_\_ YES \_\_\_\_\_ NO

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself, and that I am responsible for filing some paperwork with the carrier. Furthermore, I understand that Dr. Jonathan Golub will prepare reasonable and necessary paperwork to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dr. Golub (Southside Chiropractic) will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care and treatment, any fees for professional services rendered me will immediately be due and payable.

Please note that this form, treatment notes, and/or reports will be provided to the insurance carrier as requested and authorized.

Patient's Signature: **X**

Today's Date: \_\_\_\_\_

Parent/Guardian/Spouse

Signature authorizing care: \_\_\_\_\_

#### MARK AREAS OF PAIN

