# White Rock Chiropractic

718 N. Buckner Blvd. Ste. 100
Dallas, Tx. 75218

**Name**

Name _____ Date _____/_____/_____

Job Status: Full Duty Light Duty Off Work Not Employed

Occupation:_____

**History of incident**

Date of Injury / Accident: _____/_____/_____ Time of Day: _____ A.M. / P.M.

If MVA, were you the: DRIVER PASSENGER (circle one) Were you seatbelted: YES NO (circle one)

Please describe how your accident occurred_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

If Auto Accident please diagram as follows: ( mark your vehicle **A** and other vehicle(s) **B**, **C**, **D**, etc.)

| | |
|---|---|
| A B | |

Have you received treatment as a result of the above mentioned accident? If so, where? and when?

_____

_____

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**History of Incident - cont.**

Please check any of the following conditions you have experienced since the accident:

| | | | | | |
|---|---|---|---|---|---|
| _____ | Headaches | | | _____ | Abdominal Pain |
| _____ | Neck Pain | | | _____ | Chest Pain |
| _____ | Mid Back Pain | | | _____ | Fatigue |
| _____ | Low Back Pain | | | _____ | Irritability |
| _____ | Shoulder Pain | L | R | _____ | Nervousness |
| _____ | Elbow Pain | L | R | _____ | Difficulty with Balance |
| _____ | Wrist Pain | L | R | _____ | Difficulty Walking |
| _____ | Hand Pain | L | R | _____ | Weakness |
| _____ | Hip Pain | L | R | _____ | Swelling |
| _____ | Thigh Pain | L | R | _____ | Difficulty Sleeping |
| _____ | Knee Pain | L | R | _____ | Emotional Distress |
| _____ | Leg Pain | L | R | _____ | Difficulty Standing |
| _____ | Ankle Pain | L | R | _____ | Difficulty Sitting |
| _____ | Foot Pain | L | R | _____ | Sexual Dysfunction |
| _____ | Jaw Pain | L | R | _____ | Dizziness |

Other: _____

_____

Are you currently taking any medications for this condition? YES NO Other Condition(s)? YES NO

If so please list : _____

_____

Doctor's Notes: _____

_____

_____

_____