



Name _____ Date _____
 Address _____
 City _____ State _____ ZIP _____
 Home Phone _____ Work _____ Cell _____
 E-mail Address _____ Social Security # _____
 Birthdate _____ Age _____ Sex M F Married/Single/Widowed/Divorced
 Number of Children _____ Referred to this Office By _____
If a Minor (under 18 years old), name and address of responsible parent/guardian:
 Name _____ Date _____
 Address _____
 City _____ State _____ ZIP _____
 Home Phone _____ Work _____ Cell _____

*******ACCIDENT INFORMATION*******

1. Date of Accident _____ Time of Day _____
2. Were You: ___ Driver ___ Passenger ___ Front Seat ___ Back Seat
3. Number of people in your vehicle? ___ Were you wearing seat belts? ___ Yes ___ No
4. What direction were you headed? ___ North ___ East ___ South ___ West
 on (name of street) _____
5. What direction was the other vehicle headed? ___ North ___ East ___ South ___ West
6. Were you struck from: ___ Behind ___ Front ___ Left side ___ Right side
7. Approximate speed of your car _____ mph Other car _____ mph
8. Were you knocked unconscious? ___ Yes ___ No If yes, for how long? _____
9. Were police notified? ___ Yes ___ No
10. In your own words, please describe the accident: _____

11. Did you have any physical complaints BEFORE THE ACCIDENT? ___ Yes ___ No
 If yes, describe: _____

12. Please describe how you felt:
 - a. DURING the accident: _____
 - b. IMMEDIATELY AFTER the accident: _____
 - c. LATER THAT DAY: _____
 - d. THE NEXT DAY: _____
13. Were you taken to the hospital after THIS accident? _____

14. What are your PRESENT complaints and symptoms? _____

15. Do you have any congenital (from birth) factors which relate to this problem? _____

16. Do you have any previous illnesses which relate to this case? ___ Yes ___ No
 If yes, please describe: _____

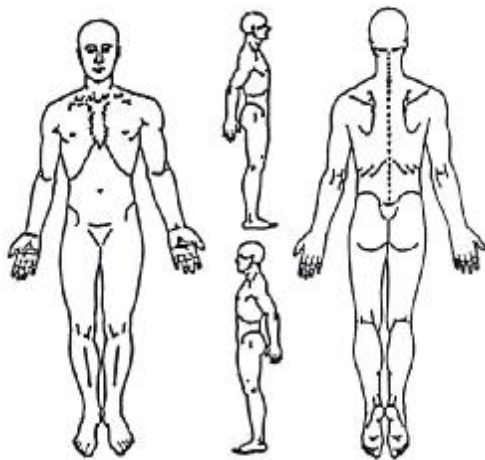
17. Have you ever been involved in an accident before? ___ Yes ___ No
 If yes, please describe: _____

18. Have you been treated by another doctor since the accident? ___ Yes ___ No
 If yes, names: _____
19. Since this injury occurred, are your symptoms: ___ Improving ___ Getting Worse ___ Same

20. CIRCLE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

- | | | | | |
|-------------------|--------------------|-----------------------|-----------------|---------------|
| HEADACHE | IRRITABILITY | NUMBNESS-TOES | FACE FLUSHED | FEET COLD |
| NECK PAIN | CHEST PAIN | SHORTNESS-BREATH | BUZZING IN EARS | HANDS COLD |
| NECK STIFF | DIZZINESS | FATIGUE | LOSS OF BALANCE | STOMACH UPSET |
| SLEEPING PROBLEMS | HEAD IS HEAVY | DEPRESSION | FAINTING | CONSTIPATION |
| BACK PAIN | PIN/NEEDLES – ARMS | LIGHT SENSITIVE - EYE | LOSS OF SMELL | COLD SWEATS |
| NERVOUSNESS | PIN/NEEDLES – LEGS | LOSS OF MEMORY | LOSS OF TASTE | FEVER |
| TENSION | NUMBNESS – FINGERS | EARS RING | DIARRHEA | |

Mark the exact location of your symptoms on the diagram:



- A = Ache
- P = Pins & Needles
- B = Burning
- S = Stabbing
- N = Numbness
- O = Other

COMMENTS:

21. Have you lost time from work as a result of this accident? Yes No

a. Last day worked: _____

b. Type of Employment: _____

c. Present Salary; _____

d. Are you being compensated for time lost from work? Yes No
 If yes, type of compensation you are receiving: _____

22. Do you notice any activity restrictions as a result of this injury? Yes No
 If yes, please describe: _____

23. Was there any damage to your car? Yes No

24. Other pertinent information: _____

25. If you are female, are you pregnant? Yes No

*******PAST HEALTH*******

Other Conditions (current/past) _____

Surgeries _____

Broken Bones _____

Major Trauma/Car Accidents _____

Medications/Supplements _____

Last Doctor Seen _____

Last Physical _____

Xrays/MRI/CT _____

Circle any of the following diseases you have had:

- | | | | |
|-----------------|----------------|---------------|--------------------|
| APPENDICITIS | MALARIA | CHICKEN POX | ALCOHOLISM |
| SCARLET FEVER | TUBERCULOSIS | DIABETES | VENEREAL INFECTION |
| DIPHTHERIA | WHOOPING COUGH | CANCER | ARTHRITIS |
| TYPHOID FEVER | ANEMIA | HEART DISEASE | EPILEPSY |
| PNEUMONIA | MEASLES | GOITER | MENTAL DISORDER |
| RHEUMATIC FEVER | MUMPS | INFLUENZA | LUMBAGO |
| POLIO | SMALL POX | PLEURISY | ECZEMA |

*******EMPLOYMENT INFORMATION*******

Employer _____ Occupation/Title _____

Employer Address/Phone _____

City _____ State _____ ZIP _____

Schlenker Chiropractic & Associates

• Dr. Jason Schlenker, D.C., CCSP® •
6148 Elliott St.
West Linn, OR, 97068
Phone: 503.908.0582
Fax: 503.908.0583

AUTO ACCIDENT / PERSONAL INJURY INSURANCE VERIFICATION

Name _____ Patient ID # _____ Date of Accident: _____

NOTE: When involved in an auto accident, medical claims are managed through each driver's own auto insurance. For example, if you are rear-ended and the accident is deemed entirely the other party's fault, any medical care provided to you as an injured party is still handled through your auto insurance policy.

If you are seeking medical care related to an auto accident, contact your auto insurance company and file a claim. Inform them that you are seeking medical attention related to the accident and write down the following information as your proof of insurance for the medical facility. It is against the law for your insurance company to raise your rates for filing a med-pay (personal injury) claim.

YOUR AUTO INSURANCE (PIP)

Name of Insured: _____ Policy #: _____

Insurance Company: _____ Claim #: _____

Insurance Company Address (where claims should be sent):

City _____ State _____ ZIP _____

Name of the Claims Adjuster assigned to your claim: _____

Claims Adjuster's Phone Number: _____

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Health and Medical Information Release Form

I, _____, give permission to Dr. Jason Schlenker, DC, CCSP®, his staff, associates, and employees of Schlenker Chiropractic & Associates to share private and medical information with my medical doctor, _____, as well as his or her staff, employees, and associates. Also, my medical doctor, as well as his or her staff, employees, and associates have my permission to share personal and medical information with Dr. Schlenker and his staff.

Signature: _____ Date: _____

Patient Information

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Date of Birth: _____

Medical Doctor Information

Name of Doctor: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____