

Winston-Salem (336) 768-1004 • Fax (336) 659-1373 3570 Vest Mill Road,#B • Winston-Salem, NC 27103

NEW PATIENT REGISTRATION AND AUTO ACCIDENT QUESTIONNAIRE

Steve Liringis, DC John Robinson, DC

. 1		ABOUT YOU
Today's Date:///		
Patient Name:LAST	FIRST	
☐ Male ☐ Female	FIRST	MI
Birthdate:// Age:	SS#:	
Mailing Address:		
CITY	STATE	ZIP
••••		
Home Phone #:		
E-mail Address:		
Employer:	-	
Employer's Address:		
CITY	STATE	ZIP
Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced	□ Separated □ Widowed	
Are you a full time student? ☐ Yes ☐ No		
Do you reside with a relative? ☐ Yes ☐ No		
Spouse's Name:		
Do you have children? ☐ Yes ☐ No How many?		
.2		F EMERGENCY
Whom should we contact?		
Relationship:		
Home Phone #:	Cell Phone #:	
Work Phone #:	_ Ext:	
Who is your medical doctor?		
Medical doctor's phone #:		

Date of Accident:	3	QUESTION	S ABOUT ACCIDENT
Specific location of accident? 2. Describe in detail, in your own words, how the accident happened? 3. In the accident. Were you the Upriver Upassenger Upedestrian Uother 4. Did your vehicle strike the other vehicle? Ups	Y		
2. Describe in detail, in your own words, how the accident happened?		Hour:	
3. In the accident: Were you the Driver Passenger Pedestrian Other 4. Did your vehicle strike the other vehicle? Yes No 5. Did the other vehicle strike your car? Yes No 6. Were you struck from? Behtind Front Driver of Your Vehicle Driver of the Other Vehicle No Citations Given 8. Were police at the scene? Yes No If Yes, was a report made? Yes No 9. Were you wave of impending crash? Yes No If Yes, was a report made? Yes No 10. Head Position at time of impact: Forward Left Right Up Down 11. Did your body hit anything? Yes No If Yes, describe: 12. Did air bag deploy? Yes No If Yes, describe: 13. Ure you wavering a hat or eye or sunglasses? Yes No If Yes, were you struck by air bag? Yes No Were you burned? Yes No 13. Were you wearing a hat or eye or sunglasses? Yes No If Yes, were they still on after crash? Yes No 14. Did you lose consclousness? Yes No If Yes, were you defined they go were in? Amount of damage 15. Estimated damage to the vehicle you were in? Amount of damage 16. Your speed at time of accident 17. Road Conditions: Dry Damp We Danow De Other 18. Was the at fault driver intoxicated or under the influence of drugs? Yes No 14. Were you seen in the ER? Yes No 15. Were you taken by ambulance? Yes No 16. Other treatment? 17. Were you seen in the ER? Yes No 17. Were you taken by ambulance? Yes No 18. Was the at fault driver intoxicated or under the influence of drugs? Yes No 18. Were you taken by ambulance? Yes No 19. Did ER doctor write you out of work? Yes No 19. Did ER doctor write you out of work? Yes No 19. Did ER doctor write you out of work? Yes No 19. Did ER doctor write you out of work? Yes No 19. Did ER doctor write you out of work? Yes No 19. Did ER doctor write you out of work? Yes No 19. Date you were back? Yes No 19. Date you work back? No 19. Date you work back? No 19. Date you work back? No 19. Date you work b			
4. Did your vehicle strike the other vehicle? □ Yes □ No 5. Did the other vehicle strike your car? □ Yes □ No 6. Were you struck from? □ Behind □ Front □ Driver Side □ Passenger Side 7. Were traffic citations issued to? □ You □ Driver of Your Vehicle □ Driver of the Other Vehicle □ No Citations Given 8. Were plote at the scene? □ Yes □ No 9. Were you aware of impending crash? □ Yes □ No 10. Head Position at time of impact: □ Froward □ Left □ Right □ Up □ Down 11. Did your body hit anything? □ Yes □ No If Yes, describe: □ Polid air bag deploy? □ Yes □ No If Yes, describe: □ Polid air bag deploy? □ Yes □ No If Yes, were you struck by air bag? □ Yes □ No Were you burned? □ Yes □ No 13. Were you wearing a hat or eye or sunglasses? □ Yes □ No If Yes, were they still on after crash? □ Yes □ No 14. Did you lose consciousness? □ Yes □ No If Yes, sere they still on after crash? □ Yes □ No 15. Estimated damage to the vehicle you were in? Amount of damage 16. Your speed at time of accident □ Polid Interpretation of the Spiral	2. Describe in detail, in your own words, now the accident happened		
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4. Did your vehicle strike the other vehicle? □ Yes □ No 6. Were you struck from? □ Behind □ Front □ Driver Side □ Passenger Side 7. Were traffic citations issued to? □ You □ Driver of Your Vehicle □ Driver of the Other Vehicle □ No Citations Given 8. Were plous at the score? □ Yes □ No 9. Were you aware of impending crash? □ Yes □ No 10. Head Position at time of impact: □ Froward □ Left □ Right □ Up □ Down 11. Did your body hit anything? □ Yes □ No 11. Did your body hit anything? □ Yes □ No 12. Did air bag deploy? □ Yes □ No 13. Were you wearing a hat or eye or sunglasses? □ Yes □ No 14. Did you lose consciousness? □ Yes □ No 15. Very you wearing a hat or eye or sunglasses? □ Yes □ No 16. Your speed at time of accident 17. Road Conditions: □ Dry □ Damp □ Wet □ Snow □ Ice □ Other 18. Was the at fault driver intoxicated or under the influence of drugs? □ Yes □ No 17. Were you seen in the ER? □ Yes □ No 18. Were you taken by ambulance? □ Yes □ No 19. Were you taken by ambulance? □ Yes □ No 19. Were you taken by ambulance? □ Yes □ No 19. Were you taken by ambulance? □ Yes □ No 19. Other treatment? □ Yes □ No, If Yes, which body parts x-rayed 19. Under the dedication: Name of Hax: □ Ice □ Medication: Name of Hax: □ Ice □ None 19. Lol Down of Yes, □ No, If Yes, which body parts x-rayed 19. Did Br doctor write you out of work? □ Yes □ No If Yes, give dates 19. Did Br doctor write you out of work? □ Yes □ No If Yes, give dates 19. Did Br doctor write you out of work? □ Yes □ No If Yes, give dates 19. Date you went back? OTHER MEDICAL PROVIDERS OTHER THAN HOSPITAL/EMERGENCY ROOM 11. Is Liringis Chiropractic the only doctor's office you have been to for this accident? □ Yes □ No 11. Is Liringis Chiropractic the only doctor's office you have been to for this accident? □ Yes □ No 16. Other treatment? □ Yes □ No If Yes, which hospital: 19. Date you went back? □ Yes □ No If Yes, which hospital: 10. Date you went back? □ Yes □ No If Yes, which hospital: 11. Did A Doctor or Physican Assistant write you out of work? □ Yes □			
5. Did the other vehicle strike your car?	· · · · · · · · · · · · · · · · · · ·	Other	
6. Were you struck from? □ Behind □ Front □ Driver Side □ Passenger Side 7. Were traffic citations issued to? □ You □ Driver of Your Vehicle □ Driver of the Other Vehicle □ No Citations Given 8. Were police at the scene? □ Yes □ No □ If Yes, was a report made? □ Yes □ No 9. Were you aware of impending crash? □ Yes □ No 10. Head Position at time of impact □ Forward □ Left □ Right □ Up □ Down 11. Did your body hit anything? □ Yes □ No □ If Yes, describe: □ 12. Did air bag deploy? □ Yes □ No □ If Yes, were you struck by air bag? □ Yes □ No Were you burmed? □ Yes □ No 14. Did you lose consciousness? □ Yes □ No □ If Yes, were they still on after crash? □ Yes □ No 14. Did you lose consciousness? □ Yes □ No □ If Yes, or how long 15. Estimated damage to the vehicle you were in? Amount of damage 16. Your speed at time of accident 17. Road Conditions: □ Dry □ Damp □ Wet □ Snow □ Ice □ Other 18. Was the at fault driver intoxicated or under the influence of drugs? □ Yes □ No HOSPITAL / EMERGENCY ROOM TREATMENT 1. Were you seen in the ER? □ Yes □ No 2. If Yes, which hospital? 3. Were you taken by ambulance? □ Yes □ No 4. Date seen if not taken by ambulance? 5. Was treatment given? □ Yes □ No, If Yes, □ Injection □ Brace, □ Physical therapy □ Cane/Crutch 6. Other treatment? 6. Other treatment? 7. Were x-rays taken? □ Yes □ No, If Yes, which body parts x-rayed (If you have a report - please give to our staff - so copy can be made) 8. Lab work? □ Yes □ No Results 10. Did ER doctor write you out of work? □ Yes □ No If Yes, give dates 11. Did ER doctor write you a work restriction? □ Yes □ No If Yes, give dates 11. Did ER doctor write you a work restriction? □ Yes □ No If Yes, give dates 12. Did you go back to the ER? □ Yes □ No If Yes, which hospital: 13. Date you went back? OTHER MEDICAL PROVIDERS OTHER THAN HOSPITAL/EMERGENCY ROOM 1. Is Liringis Chiropractic the only doctor's office you have been to for this accident? □ Yes □ No If no, fill in the following: Doctor: □ Specialty: □ No If Yes, give dates Did a Doctor or Phys	•		
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10. Head Position at time of impact:	·	le? ☐ Yes ☐ No	
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13. Were you wearing a hat or eye or sunglasses? Yes No If yes, were they still on after crash? Yes No 14. Did you lose consciousness? Yes No If Yes, for how long 14. Did you lose consciousness? Yes No If Yes, for how long 15. Estimated damage to the vehicle you were in? Amount of damage 16. Your speed at time of accident 17. Road Conditions: Dry Damp Wet Snow Ice Other 18. Was the at fault driver intoxicated or under the influence of drugs? Yes No HOSPITAL / EMERGENCY ROOM TREATMENT 1. Were you seen in the ER? Yes No 2. If Yes, which hospital? 3. Were you taken by ambulance? Yes No 4. Date seen if not taken by ambulance? Yes No 4. Date seen if not taken by ambulance? Yes No 5. Was treatment given? Yes No If Yes, Injection Brace, Physical therapy Cane/Crutch 6. Other treatment? 7. Were x-rays taken? Yes No, If Yes, which body parts x-rayed (If you have a report - please give to our staff - so copy can be made) 8. Lab work? Yes No Results: 9. Follow-up instructions: None 10. Did ER doctor write you out of work? Yes No If Yes, give dates 11. Did ER doctor write you a work restriction? Yes No If Yes, give dates 12. Did you go back to the ER? Yes No If yes, which hospital: 13. Date you went back? OTHER MEDICAL PROVIDERS OTHER THAN HOSPITAL/EMERGENCY ROOM 14. Is Liringis Chiropractic the only doctor's office you have been to for this accident? Yes No 15. Is Liringis Chiropractic the only doctor's office you have been to for this accident? Yes No 16. Other treating? Yes No 17. Arays Made? If so, which area was taken 18. Date you went back? 19. Date you out of Physican Assistant write you out of work? Yes No If Yes, give dates 19. Did a Doctor or Physican Assistant write you awork restriction? Yes No If Yes, give dates 19. Did a Doctor or Physican Assistant write you awork restricti	11. Did your body hit anything? 🗀 Yes 🗀 No If Yes, describe:		
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17. Road Conditions:	· ·	•	
HOSPITAL / EMERGENCY ROOM TREATMENT			
1. Were you seen in the ER?			
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2. If Yes, which hospital? 3. Were you taken by ambulance? □ Yes □ No 4. Date seen if not taken by ambulance? 5. Was treatment given? □ Yes □ No If Yes, □ Injection □ Brace, □ Physical therapy □ Cane/Crutch □ Ce □ Medication: Name of Rx: 6. Other treatment? 7. Were x-rays taken? □ Yes □ No, If Yes, which body parts x-rayed	4 HOSPITAL /	EMERGENCY	ROOM TREATMENT
3. Were you taken by ambulance?			
4. Date seen if not taken by ambulance? 5. Was treatment given?			
5. Was treatment given?			
6. Other treatment?	5. Was treatment given? $\ \ \Box$ Yes $\ \ \Box$ No If Yes, $\ \ \Box$ Injection $\ \ \Box$ Brace,		ne/Crutch
7. Were x-rays taken?			
(If you have a report - please give to our staff - so copy can be made) 8. Lab work? Yes No Results: No Re		ed	
8. Lab work? \(\text{ Yes } \) No Results: \(\text{ Yes } \) No Results: \(\text{ Yes } \) No If Yes, give dates \(\text{ 11. Did ER doctor write you a work restriction? } \) Yes \(\text{ No If Yes, give dates} \) 12. Did you go back to the ER? \(\text{ Yes } \) No If yes, which hospital: \(\text{ 13. Date you went back?} \) 13. Date you went back? \(\text{ Ves } \) No If yes office you have been to for this accident? \(\text{ Yes } \) No If no, fill in the following: Doctor: \(\text{ Specialty: } \) Date first seen: \(\text{ No If Yes, give dates} \) Currently treating? \(\text{ Yes } \) No Did a Doctor or Physican Assistant write you a work restriction? \(\text{ Yes } \) No If Yes, give dates \(\text{ In No If Yes, give dates} \)			
10. Did ER doctor write you out of work?	8. Lab work? ☐ Yes ☐ No Results:		
11. Did ER doctor write you a work restriction?			
12. Did you go back to the ER?		_	
OTHER MEDICAL PROVIDERS OTHER THAN HOSPITAL/EMERGENCY ROOM 1. Is Liringis Chiropractic the only doctor's office you have been to for this accident?		_	
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If no, fill in the following: Doctor: Specialty: Date first seen: X-rays Made? If so, which area was taken Currently treating? □ Yes □ No Did a Doctor or Physican Assistant write you out of work? □ Yes □ No If Yes, give dates Did a Doctor or Physican Assistant write you a work restriction? □ Yes □ No If Yes, give dates			
Doctor: Specialty: Date first seen: X-rays Made? If so, which area was taken Currently treating? □ Yes □ No Did a Doctor or Physican Assistant write you out of work? □ Yes □ No If Yes, give dates Did a Doctor or Physican Assistant write you a work restriction? □ Yes □ No If Yes, give dates		been to for this accident?	u res u no
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Currently treating? □ Yes □ No Did a Doctor or Physican Assistant write you out of work? □ Yes □ No If Yes, give dates Did a Doctor or Physican Assistant write you a work restriction? □ Yes □ No If Yes, give dates			
Did a Doctor or Physican Assistant write you out of work? ☐ Yes ☐ No If Yes, give dates			
Did a Doctor or Physican Assistant write you a work restriction? 🛘 Yes 🗖 No If Yes, give dates			
		_	
Special test: Referred to:			
	Special test: Referred to:		

Doctor's Initials: ______Staff Initials: _____

tajactor mantaning jour boar	ily injury cl	aim:		Clain	n #:	
If you do not know the claim						
Adjuster Phone Number:						
7					HEAI	TH HISTOR
1. Do you have or hav	e you had a	any of the following dis	eases, m	edical condition	s or proced	ures?
☐ Yes Tuberculosis		Thyroid Disease		Diabetes		Fainting/Seizures/Epilepsy
☐ Yes Kidney Disease	☐ Yes	Gout	☐ Yes	Hepatitis		Venereal Disease
☐ Yes Sciatica ☐ Yes Colon Disease	⊔ Yes	Heart Disease/Heart Attack Heart Murmur	☐ Yes	Pollo/MS Bleeding		Rheumatic Fever Sinus Problems
☐ Yes Paralysis	□ Yes	Congenital Heart Defect	☐ Yes	Ulcers/Colitis		Frequent Neck Pain
☐ Yes Anemia	□ Yes	Heart Surgery/Pacemaker	□ Yes	Asthma		Lower Back Problems
☐ Yes Lung Disease	☐ Yes	Transfusion	☐ Yes	AIDS	☐ Yes	Hepatitis
☐ Yes Stomach/Ulcer	Yes	Cancer	Yes	HIV	Yes	Glaucoma
☐ Yes Hi/Low Blood Pressure		Chemotherapy	Yes		☐ Yes	Artificial Bone/Joint/Implants
☐ Yes Stroke	□ Yes			Shingles		
☐ Yes Seizures		Drug Dependence		Psychiatric Problems		
2. Please list any surgeries wi	ith dates and	d/or other serious medica	al conditio	on(s) not listed abo	ove:	
	حام طفانين مفص	.				
List any past serious accide Please list apything that you						
1. Please list anything that you	-					
. Liet any tamily Haalth Hieta	rv:					
	-					
	-					
 List any family Health Histo Do you take supplements of Do you smoke? ☐ Yes ☐ 	r vitamins?	□ Yes □ No D	o you ex	ercise? 🛚 Yes	⊒ No	hours per week
6. Do you take supplements o 7. Do you smoke? □ Yes □	or vitamins? • No Hov	□ Yes □ No D w much?	o you ex	ercise? 🗖 Yes 🛚 Hov	⊐ No v long?	hours per week
6. Do you take supplements of 7. Do you smoke? ☐ Yes ☐ 8. For women: Are you taking	or vitamins? No How birth contro	□ Yes □ No D w much? vl? □ Yes □ No Are y	o you ex	ercise? 🗅 Yes 🗆 Hov ng? 🗅 Yes 🗅 No	□ No v long? o	hours per week
6. Do you take supplements o 7. Do you smoke? □ Yes □	or vitamins? No How birth contro	□ Yes □ No D w much? vl? □ Yes □ No Are y	o you ex	ercise? 🗅 Yes 🗆 Hov ng? 🗅 Yes 🗅 No	□ No v long? o	hours per week
6. Do you take supplements of 7. Do you smoke? ☐ Yes ☐ 8. For women: Are you taking 9. Are you pregnant? ☐ Ye	or vitamins? No How birth contro	☐ Yes ☐ No ☐ D w much? bl? ☐ Yes ☐ No Are y If so, how many weeks	o you ex you nursir	ercise?	□ No v long? o	hours per week
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5. Do you take supplements of 7. Do you smoke? Yes 5. For women: Are you taking 9. Are you pregnant? Yes We invite you to discuss with understanding between provements. HIPAA Compliance - Our officegal duties and privacy practice.	or vitamins? No How birth controls No No us any que dider and partices with residers	Yes No D w much? If so, how many weeks estions regarding our servicent. Hed by law to maintian the spect to your protected he	o you ex you nursir ? vices. The HIPAA N	ercise?	No No Volong? Oces are base	ed on a friendly, mutual
5. Do you take supplements of 7. Do you smoke? Yes 5. For women: Are you taking 9. Are you pregnant? Yes We invite you to discuss with understanding between provements. HIPAA Compliance - Our officegal duties and privacy practice.	or vitamins? No How birth controls No No us any que dider and partices with residers	Yes No D w much? If so, how many weeks estions regarding our servicent. Hed by law to maintian the spect to your protected he	o you ex you nursir ? vices. The HIPAA N	ercise?	No No Volong? Oces are base	ed on a friendly, mutual
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