KEHR CHIROPRACTIC
2008 3RD ST., SUITE B
LA GRANDE, OR 97850
541-963-9632

KEHR CHIROPRACTIC

DANIEL E. KEHR, D.C.
JASON M. KEHR, D.C.

Confidential Patient Information
Auto Accident

Name _____ Date _____
Street Address _____
City_____ State_____ Zip_____ Phone #_____
SS#_____ Birth Date_____ Age_____ Sex: M or F
Marital Status: S M D W Race_____ Drivers Lic#_____
Employer_____ Student? Y or N School_____
Employer address_____
street city state zip
Work Phone # _____ Job Duties_____
Spouse/Guardian_____ Phone #_____
Spouse address_____
street city state zip
In case of Emergency Contact_____ Phone #_____
Nearest relative (not living with you?)_____ Phone #_____

Insurance Information: Date of Injury _____

Drivers Insurance Company_____ Policy #_____
(the car you were in) Claim #_____ Adjusters Name_____
Phone # _____ Name of Insured_____
Were you: *Driver* or *Passenger* Relationship to Insured_____

Other Drivers Ins Company_____ Policy #_____
(auto that hit your car Claim #_____ Adjusters Name_____
or was hit by your car) Phone #_____ Name of Insured_____

Attorney's Name:_____ Phone #_____
Have you signed? Y or N Date of appt: _____

I verify that to the best of my knowledge the above information is true.

Patient Signature_____ Date_____

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Patients Complaints

Name_____Sex: M or F Date of Birth_____
Age_____Height _____Weight_____

What physical problem bothers you most?_____
What caused it?_____
When did it start?_____Describe the pain_____
Where is the pain exactly located?_____
What aggravates it?_____
What relieves it?_____
Has this happened before? Yes or No If yes, when?_____
What is the next most bothersome physical problem?_____
_____
What caused it?_____When did it start?_____
Describe the pain_____Where is the pain located?_____
What aggravates it?_____What relieves it?_____
Has this happened before? Yes or No If yes, when? _____

Please check any of the following you are now experiencing:

_____Headaches
_____Dizziness
_____Restlessness
_____Insomnia
_____Constipation
_____Difficulty swallowing
_____Coldness in hands or feet
_____Eye complaints
_____Ear complaints
_____Behavior changes
_____Fainting spells
_____Clumsiness
_____Loss of strength in arms
_____Pain &/or numbness in legs/feet
_____Pain &/or numbness in arms/hands
_____Burning muscle pain
_____Loss of strength in legs
_____Chest pain or disturbances
_____Loss of strength in legs

Do you have or have you ever had:

_____Heart disease
_____Stroke
_____Diabetes
_____Other: _____
_____Cancer

Past History:

List any previous injuries: (ie: slips, falls, auto accidents…and give dates occurred)
1._____
2._____
3._____
List all operations or hospitalizations(give details): _____
List all medications you are now taking and what it is for:_____
Allergies: Please list_____
Do you smoke? Yes or No If yes, how much per day?_____

Women: Is there any chance you could be pregnant? Yes or No

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Automobile Accident History

Name_____Sex: M or F Date of birth_____

Date of Accident_____Time_____AM or PM

Were you driving? Yes or No Were you a pedestrian? Yes or No
Were you a passenger? Yes or No If yes, where were you seated?_____
Did you have your seat belt on? Yes or No Shoulder harness? Yes or No

What kind of car were you in? (make-model-year)_____
Names of other people in the car:
Name & address:_____
Name & address:_____
Name & address:_____

Briefly state how the accident happened in your own words. (street names also please):

_____
_____
_____

What kind of car was the other car? (make-model-year)_____

What were the weather conditions like?_____

Did you hit any part of your body in the car? Yes or No If yes, which part & how?

_____

Did you go to the Emergency room? Yes or No If yes, when & how did you get there?

_____

Have you received care from any other healthcare provider? Yes or No If yes, who?

_____

Name_____Address_____

Have you ever been injured in a similar accident? Yes or No If yes, explain
(When, where & indicate if you were having any continued problems prior to the injury)

_____

Just before the accident, how did you feel?_____

Have you ever been seen in this clinic before?_____

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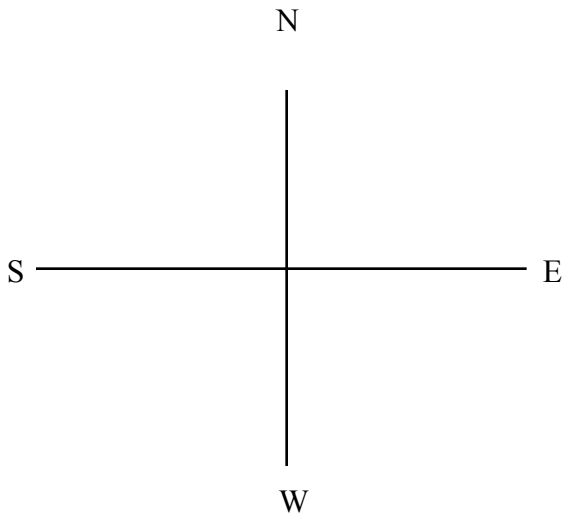
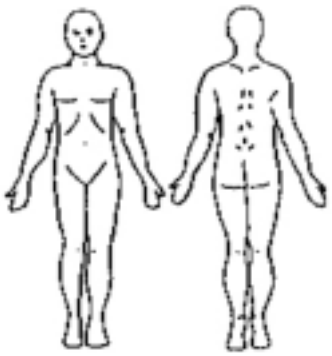
Automobile Accident History

PLEASE DRAW THE ACCIDENT



MARK PAIN AREA BELOW

+++ Burning
000 Stabbing
- - - Sharp
| | | Constant



Patient Signature _____

Date _____

Staff Signature _____