

RHODES TO HEALTH CHIROPRACTIC
Patient Accident History

NAME _____ DATE _____

List or circle details on all AUTOMOBILE ACCIDENTS you have had that were greater than 3 miles per hour. Please list the most recent accident first.

DATE: _____ Driver Passenger (Front Back)
 SIDE OF IMPACT: Front Back L R SPEED AT IMPACT: _____ MPH
 Hospitalized? Y N Where? _____
 X-Rays Taken? Y N Where? _____
 Chiropractic Care Given? Y N Where? _____

DATE: _____ Driver Passenger (Front Back)
 SIDE OF IMPACT: Front Back L R SPEED AT IMPACT: _____ MPH
 Hospitalized? Y N Where? _____
 X-Rays Taken? Y N Where? _____
 Chiropractic Care Given? Y N Where? _____

Please list or circle details on FALLS you have experienced.
 (Ice, down stairs, falls as a child, biking, running, etc.)

DATE: _____ Where was fall: Home Work Outside Inside
 Hospitalized? Y N Where? _____
 X-Rays Taken? Y N Where? _____
 Chiropractic Care Given? Y N Where? _____

Please list or circle details on all WORK RELATED accidents (Even if Not Reported)

DATE: _____ Place of employment: _____
 Nature of Injury: _____
 Hospitalized? Y N Where? _____
 X-Rays Taken? Y N Where? _____
 Chiropractic Care Given? Y N Where? _____

Please list details on all SURGERIES.

DATE: _____ Procedure: _____ Outcome: _____ Dr: _____
 DATE: _____ Procedure: _____ Outcome: _____ Dr: _____
 DATE: _____ Procedure: _____ Outcome: _____ Dr: _____

Problem List

DR Name/Facility	Problem	Type of Treatment	From when to when

PREGNANCY RELEASE: This is to certify that to the best of my knowledge I am not pregnant and that Dr. Paul Rhodes and his associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child. Date of last menstrual period reason for cessation of menstrual periods _____.

 Patient/ Guardian Signature _____
 Date