Southside Chiropractic

Dr. Jonathan Golub
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Bellmore, NY 11710
(516) 783-3700

NAME: ______________________________ DATE: _____________ AGE: _____ SEX: ____

ADDRESS: _____________________________________ DATE OF BIRTH: ________________

HOME PHONE #: ________________ WORK #: ________________ CELL: _______________

SOCIAL SECURITY #: ____________________ MARITAL STATUS: ______ # CHILDREN:____

AUTO INSURANCE COMPANY: _____________________ CLAIM #: ______________________

RESPONSIBLE PARTY'S NAME (who the auto was owned and insured by): ___________________________

ADDRESS (if different than your own): ____

ATTORNEY'S NAME & PHONE: ____

NATURE OF ACCIDENT:

1. Date of accident: ____________________ Time:___________ Weather Conditions:_____________ Road Conditions:____________
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle: _______
4. Were you wearing safety belts? ________
5. Is the vehicle equipped with air bags? _____ If yes, did they deploy? _____
6. What direction were *you* headed? ( ) North ( ) South ( ) East ( ) West On (street name):____________________________
7. What direction was the *other vehicle* headed? ( ) North ( ) South ( ) East ( ) West On (street name):_________________
8. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
9. Approximate speed of your vehicle: ________MPH Other vehicle: ________MPH
10. Were you knocked unconscious? ( ) YES ( ) NO If yes, for how long? ____________________________
11. Were the police notified? ( ) YES ( ) NO
12. In you own words, please describe the accident: ____

____

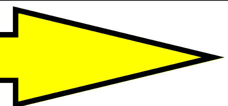
13. Please describe how you felt:

BEFORE THE ACCIDENT:_______________________ IMMEDIATELY AFTER THE ACCIDENT:___________________________

WHAT ARE YOUR **CURRENT COMPLAINTS?**:____

____

DOCTOR'S NOTES:



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14. Where were you taken after the accident? ___________________________ How did you get there? _________________________________
15. Have you seen any other doctor/health care provider for this accident? ____
16. Since this accident, are your symptoms: ( ) Better ( ) The Same ( ) Worse
17. Have you been in any accidents ***before***? ( ) YES ( ) NO If yes, please describe, including type, date, complaints and treatment:

____

____

PLEASE CHECK ALL PROBLEMS & SYMPTOMS YOU EXPERIENCE

_____ HEADACHE
_____ STIFF NECK
_____ SLEEPING PROBLEMS
_____ BACK PAIN
_____ NERVOUSNESS
_____ TENSION
_____ IRRITABILITY
_____ CHEST PAIN
_____ SKIN CHANGES
_____ DIZZINESS
_____ PINS & NEEDLES IN ARMS
_____ PINS & NEEDLES IN LEGS
_____ NUMBNESS IN FINGERS
_____ NUMBNESS IN TOES
_____ SHORTNESS OF BREATH
_____ FATIGUE
_____ DEPRESSION
_____ LIGHT BOTHERS EYES
_____ EARS RINGING / BUZZING
_____ LOSS OF BALANCE
_____ FAINTING
_____ LOSS OF SMELL / TASTE
_____ DIARRHEA
_____ UPSET STOMACH
_____ CONSTIPATION
_____ COLDS SWEATS
_____ FEVER
_____ ANY INFECTIOUS DISEASES WE SHOULD KNOW ABOUT

DOCTOR'S NOTES

PAIN IN:

NECK	L____	R____
SHOULDER	L____	R____
ARM	L____	R____
ELBOW	L____	R____
HAND	L____	R____
UPPER BACK	L____	R____
MID BACK	L____	R____
LOWER BACK	L____	R____
HIP	L____	R____
THIGH	L____	R____
CALF	L____	R____
KNEE	L____	R____
ANKLE	L____	R____
CHEST AREA	L____	R____

ABOVE STOMACH ____
BELOW STOMACH ____
GALL BLADDER AREA ____
APPENDIX AREA ____
KIDNEY AREA ____
PAINFUL MENSES ____
PROSTATE PROBLEMS ____

OTHER: ___________________

ANYTHING ELSE THE DOCTOR SHOULD KNOW?

____

____

DOCTOR'S NOTES

If **FEMALE,** is there any chance you are **PREGNANT**?
_____ **YES** _____ **NO**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself, and that I am responsible for filing some paperwork with the carrier. Furthermore, I understand that Dr. Jonathan Golub will prepare reasonable and necessary paperwork to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dr. Golub (Southside Chiropractic) will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care and treatment, any fees for professional services rendered me will immediately be due and payable.

Please note that this form, treatment notes, and/or reports will be provided to the insurance carrier as requested and authorized.

Patient's Signature: **X**____

Today's Date: ________________________________

Parent/Guardian/Spouse
Signature authorizing care: ____

MARK AREAS OF PAIN