THE NERVE HEALTH INSTITUTE
Dr. Chris Cormier, D.C.
Dr. Angelique Miller, D.C.

Claim #_____________ ***Acct. #***_________

Date of Accident__________

108 Republic Ave, Suite B
Lafayette, LA 70508
nervehealthla@gmail.com
337.456.6555
337.706.7221

Full Name:_________________________________ **Birthdate:**____________ **Age:**______

Address:_______________________________ **City:**______________ **State:**____ **Zip**_______

Phone# ______________________ **Height:**_________**Weight**____________

E-Mail:________________________________ **SS Number:**_______________________

Sex (circle one): MALE FEMALE Occupation:________________________________

Marital Status(circle one): Single Married Divorced Separated Widowed

Business/Employer:___________________________ **Business Phone#**___________________

Business Address:________________________ **City:**____________________

State:_____ **Zip:**________

How Were You Referred To this Office?____

Please List Your Top 4 Areas of Complaint

1. **Area of Complaint:**____________________________
   What percentage of your day would you say you feel this discomfort?________%
   How would you describe your pain/discomfort?(please circle all that apply):
   Sharp Stabbing Dull Achy Cramping Sore Tight Burning Tingling Numb
   Other____________________________________
   What would you rate your pain at its worst on a scale from 0-10, with "10" being the worst possible pain and "0" being no pain at all? (please circle)
   0 1 2 3 4 5 6 7 8 9 10

   Does anything make the pain better?
   Advil(Ibuprofen) Tylenol(Acetometophen) Aleve Heating Pad Ice Moving around Resting Sitting Leaning forward Leaning to the side Laying on back Standing Hot Bath/Shower Other______________________________________

   Does anything make the pain worse?
   Rising from a chair Sitting Standing Sneezing Coughing Straining during bowel movements Moving head Lifting Driving Bending Forward Twisting Moving Arms or Legs Bathing Dressing Other________________________________

2. **Area of Complaint:**____________________________

What percentage of your day would you say you feel this discomfort?________%

How would you describe your pain/discomfort?(please circle all that apply):

Sharp Stabbing Dull Achy Cramping Sore Tight Burning Tingling Numb

Other____________________________________

What would you rate your pain at its worst on a scale from 0-10, with "10" being the worst possible pain and "0" being no pain at all? (please circle)

0 1 2 3 4 5 6 7 8 9 1 0

Does anything make the pain better?

Advil(Ibuprofen) Tylenol(Acetometophen) Aleve Heating Pad Ice Moving around Resting Sitting Leaning forward Leaning to the side Laying on back Standing Hot Bath/Shower Other______________________________________

Does anything make the pain worse?

Rising from a chair Sitting Standing Sneezing Coughing Straining during bowel movements Moving head Lifting Driving Bending Forward Twisting Moving Arms or Legs Bathing Dressing Other________________________________

3. **Area of Complaint:**____________________________

What percentage of your day would you say you feel this discomfort?________%

How would you describe your pain/discomfort?(please circle all that apply):

Sharp Stabbing Dull Achy Cramping Sore Tight Burning Tingling Numb

Other____________________________________

What would you rate your pain at its worst on a scale from 0-10, with "10" being the worst possible pain and "0" being no pain at all? (please circle)

0 1 2 3 4 5 6 7 8 9 1 0

Does anything make the pain better?

Advil(Ibuprofen) Tylenol(Acetometophen) Aleve Heating Pad Ice Moving around Resting Sitting Leaning forward Leaning to the side Laying on back Standing Hot Bath/Shower Other______________________________________

Does anything make the pain worse?

Rising from a chair Sitting Standing Sneezing Coughing Straining during bowel movements Moving head Lifting Driving Bending Forward Twisting Moving Arms or Legs Bathing Dressing Other________________________________

4. **Area of Complaint:**______________________________
What percentage of your day would you say you feel this discomfort?________**%**
How would you describe your pain/discomfort?(please circle all that apply):

Sharp Stabbing Dull Achy Cramping Sore Tight Burning Tingling Numb
Other_______________________________________

What would you rate your pain at its worst on a scale from 0-10, with "10" being the worst possible pain and "0" being no pain at all? (please circle)

0 1 2 3 4 5 6 7 8 9 1 0

Does anything make the pain better?
Advil(Ibuprofen) Tylenol(Acetometophen) Aleve Heating Pad Ice Moving around
Resting Sitting Leaning forward Leaning to the side Laying on back Standing
Hot Bath/Shower Other____

Does anything make the pain worse?
Rising from a chair Sitting Standing Sneezing Coughing Straining during bowel movements Moving head Lifting Driving Bending Forward Twisting
Moving Arms or Legs Bathing Dressing Other__________________________________

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Have you lost any time at work due to this pain/discomfort?___Yes ___No
If yes, how many days have you taken off of work?________

When did this pain/discomfort begin approximately?
Immediately After The Accident Days After The Accident Weeks After The Accident

Where were you seated in the car when the accident occurred?
Driver Front Passenger Rear Driver Side Rear Passenger Side

Did your vehicle strike the other vehicle? ___Yes ___No
If yes, on what part of your car did the impact occur?
Front Driver Side Passenger Side Rear

What size was the vehicle you were driving?
Large SUV Mid-size SUV Sedan Small Car

Was your vehicle struck by another vehicle? ___Yes ___No
If yes, on what part of your car did the impact occur?
Front Driver Side Passenger Side Rear

What size was the vehicle that hit you/you hit?
Large SUV Mid-size SUV Sedan Small Car

Where were you looking at the time of the impact?
Straight Ahead To the Right To the Left To The Rear

Did you anticipate the crash before impact? ___Yes ___No

Were you wearing your seatbelt at the time of the impact? ___Yes ___No

Did your airbags deploy? ___Yes ___No

Did your head hit anything in the car at any time during the collision? ___Yes ___No

Did your body contact anything in the car during impact? (steering wheel, window, etc) ___Yes ___No

Did you lose consciousness? ___Yes ___No

Approximately how fast were you going?_______mph

Approximately how fast was the other vehicle going?_______mph

Estimated damage to your vehicle?
None Slight Visible Moderate Visible Heavy Visible Totaled

Estimated damage to the other vehicle?
None Slight Visible Moderate Visible Heavy Visible Totaled

Was EMS called to the scene?___Yes ___No
Police? ___Yes ___No Report filed? ___Yes ___No

How did you leave the scene of the accident?
Drove Away EMS Vehicle was Towed Someone picked you up

Did you go to the hospital or another medical facility after the collision? ___Yes ___No
*If yes, what was the name of the facility?______________________________

What, if any, treatment was recommended/performed?
Prescription Meds Injections Advised Me To See Another Doctor Over the Counter Meds

Did you see another doctor for these conditions?___Yes ___No
*If yes, please select the type of doctor(s) and write his/her name.
Chiropractor__________________ Orthopedist______________________
Neurologist___________________ General/Family Practitioner__________________
Physical Therapist__________________ Other(s)________________________________

Were diagnostic tests performed? ___Yes ___No
X-Rays MRI CT Scan Myelogram Other_____________

What were you diagnosed with?
Whiplash Sprain/Strain Herniated Disc_______ (level of disc if known)

Did you experience any other symptoms or sensations/ feelings at the time of the accident? Examples include: Stress, disbelief, shock, fear, dizziness, chest pain, headache, tightness, tired, upset, etc.; Please write below.

____

Do you have any (please circle): NUMBNESS TINGLING

**If so, please circle where you feel the numbness/tingling

Left arm/hand Right arm/hand Left leg/foot Right leg/foot

What medications/vitamins/supplements do you currently take daily? (please write dosage/day)

Blood Pressure Medication________________________ Cholesterol Medication_____________________

Diabetic Medication______________________________ Multi-Vitamin______________________________

Aspirin__________ Advil__________ Tylenol__________ Ibuprofen__________ Aleve_________

Motrin__________ Acetaminophen__________ Other Medications____________________________

Supplements____

Please check circle the following symptoms you have had, whether PAST, CURRENT, or BOTH

Symptom		Symptom	
Headaches	P C B	Stomach upset	P C B
Nausea	P C B	Buzz/ring in ears	P C B
Loss of smell	P C B	Depression	P C B
Neck stiff/pain	P C B	Numbness in fingers	P C B
Loss of taste	P C B	Cold feet	P C B
Loss of balance	P C B	Numbness in toes	P C B
Ulcers	P C B	Fever	P C B
Tension	P C B	Sleeping problems	P C B
Fatigue	P C B	Menstrual Pain	P C B
Dizziness	P C B	Lights bother eyes	P C B
Cold Hands	P C B	Heartburn	P C B
Irritability	P C B	Menstrual irregularity	P C B
Diarrhea	P C B	Tingling in legs	P C B
Constipation	P C B	Allergies	P C B
Cold Sweats	P C B	Sinus problems	P C B
Hot flashes	P C B	High blood pressure	P C B
Fainting	P C B	Breast problems	P C B
Urinary problems	P C B	Itching	P C B
Back pain	P C B	Bed Wetting	P C B
Asthma	P C B	Addiction	P C B
Nervousness	P C B	Swollen Glands	P C B
Arm tingling	P C B	Skin Rashes	P C B
		OTHER________________________	

P=PAST C=Current B=BOTH

Your nerve health level is a result of your genetics combined with all the physical, mental/emotional, and biochemical stress you have put your body through.
Has anyone in your family experienced any of the following conditions?

	MOM	DAD	BROTHER 1	BROTHER 2	SISTER 1	SISTER 2
DIABETES						
HIGH BLOOD PRESSURE						
CANCER						
STROKE						
LIVING						
DECEASED						

PHYSICAL STRESS:Please list all past surgeries/hospitalizations and include the approximate date(s):

Appendectomy__________ Tonsillectomy___________ Hysterectomy_________

Gall Bladder Removal______ Back____________________ Neck_________________

Hernia____________________ Leg____________________ Hip__________________

Arm_______________________ Heart(please specify)___________________________________

Other____

Have you ever had a broken/fractured bone?___Yes ____No

**If yes, please circle and write how old you were when the fracture occurred.*

Arm(R or L)________ Leg(R or L)_________ Hand(R or L)_________ Foot(R or L)_____

Ankle(R or L)______ Wrist(R or L)______ Hip(R or L)___________ Neck____________

Shoulder(R or L)______ Middle Back________ Lower Back___________

Rib______________Tailbone_____________Other____

Any other injuries/automobile accidents/falls whereby you remember even having minimal injuries like soreness or a cut or a bruise or stitches? If so, please list them.

____

____

____

BIOCHEMICAL STRESS:
Do you smoke cigarettes/cigars? ___Yes ____No
*If yes, approximately how many per day?_______

Do you drink alcohol?___Yes ____No
*If yes, approximately how many drinks per week?__________

Do you consume artificial sugars like gum, diet drinks, crystal lite, Splenda, Equal? ____Yes ____No
*If yes, approximately how many per day?________

How many VEGETABLES do you eat each day? (please CIRCLE)

0 1 2 3 4 5 6 7 8 +

How many FRUITS do you eat each day? (please CIRCLE)

0 1 2 3 4 5 6 7 8 +

How many SODAS/SOFT DRINKS do you drink each day? (please CIRCLE)

0 1 2 3 4 5 6 7 8 +

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FEMALES ONLY: a) Are you having your monthly period right now?___Yes ____No
*If no, when was the last day (include month/year) of your last menstrual period?
____
b) Are you pregnant?___Yes ____No
****If yes, how far along are you (weeks or months)?________________

••••••••••••••••••••

In case of an emergency, who should we contact?
Name: ____
Home Phone #:____________________________________
Work Phone #:_______________________________________
Relation: ____

Now we just need your permission to continue through our process!
I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature____ Date: __________________