Gentle Touch Chiropractic

Sayel Fakhoury, DC (Dr. Sal)

18399 Ventura Boulevard, Suite 241
Tarzana, CA 91356
Phone: 818-708-0477
Fax: 818-708-7902

PERSONAL INJURY HISTORY

First Name:_____ Last Name:_____ Date:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Email:_____ Cell #: _____ Home #:_____

DOB:_____ Sex: ☐ Male ☐ Female SSN:_____

Age:_____ Driver's License #: _____

Occupation:_____ Employer_____

Employer Street Address:_____

City: _____ State: _____ Zip:_____

Work email: _____ Work phone: _____

AUTO INSURANCE INFORMATION

Insurance Company Name: _____

Street Address:_____ City:_____ State:_____

Zip:_____ Phone:_____ Agent's Name:_____

Policy Holder's Name:_____ Policy #: _____

Claim #: _____ Insured's Relationship: ☐Spouse ☐ Parent ☐ Child ☐ Other

NATURE OF ACCIDENT

Did your injury occur during? ☐ Auto ☐ Slip & Fall ☐ Pedestrian ☐ Other_____

When did your accident occur? _____ Time of accident: _____

Were you: ☐ Driving ☐ Passenger ☐ Front seat ☐ Back Right ☐ Back Left ☐ Walking

☐ Other_____

Name of city where the accident occurred:_____ What direction were you headed? ☐North ☐South ☐East ☐West

Name of Street: _____

Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side

Were there any witnesses: ☐ Yes ☐ No

Were you wearing a seatbelt: ☐ Yes ☐ No

Was this vehicle equipped with airbags? ☐ Yes ☐ No If Yes, did they inflate?

Please list any part of your body that struck the interior of your vehicle:

Describe the damage to your car:

Describe the damage to the other car:

Were you able to drive your car after? ☐ Yes ☐ No

Did police or paramedics arrive at the scene? ☐ Yes ☐ No

Were you taken to the hospital? ☐ Yes ☐ No

If Yes, how did you get there?

At the hospital/ER, what did they do for you?

Were you knocked unconscious? ☐ Yes ☐ No

In your own words, please explain what happened:

Describe how you felt and what areas hurt:

During the accident: _____

Immediately after the accident:_____

Later that day:_____

The next day:_____

What is the year and model of your car?_____

What is the year and model of the other car?_____

CURRENT HEALTH CONDITION(S)

Using the adjacent body charts, please ***circle*** all affected areas.

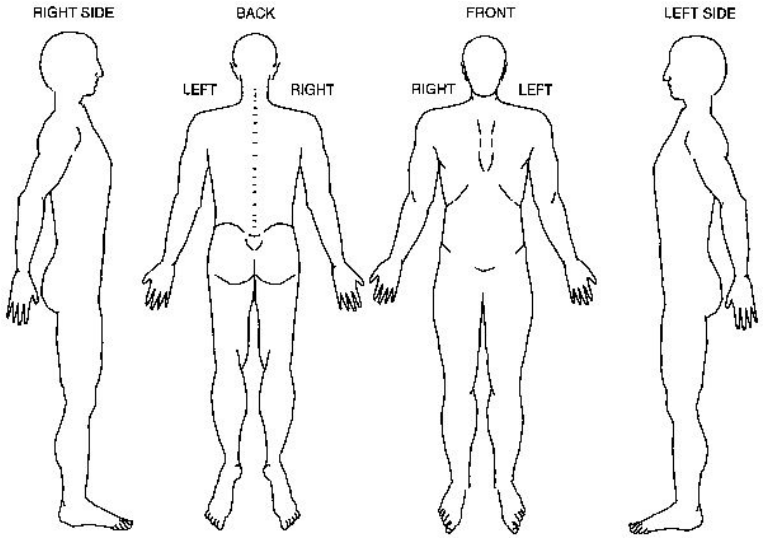
What area(s) is/are injured?

1. _____

2. _____

3. _____

4. _____



Have you been treated anywhere for this accident?

☐ Yes ☐ No

If Yes, please list the other Doctors:

1. _____

2. _____

3. _____

My condition is aggravated by:

☐ Standing too long ☐ Stooping ☐ Laying on my back ☐ Bending ☐ Pulling

☐ Sitting too long ☐ Driving ☐ Laying on my stomach ☐ Other_____

Is your condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine

If so, how:_____

Have you missed work because of the accident? ☐ Yes ☐ No

If yes, date of disability from_____ to _____

Are you taking any of the following medications?

☐ Nerve Pills ☐ Painkillers (including aspirin) ☐ Muscle Relaxants ☐ Blood thinners

☐ Tranquilizers ☐ Insulin ☐ Other(s)_____

Since your accident, please check the symptoms that you are now experiencing:

☐ Headaches ☐ Dizziness ☐ Neck Pain ☐ Upper Back Pain

☐ Mid Back Pain ☐ Lower Back Pain ☐ Chest Pain ☐ Numbness

☐ Tingling extremities ☐ Upper extremity arm pain ☐ Lower extremity leg pain ☐ Vomiting/Nausea

☐ Other_____

TREATMENT CONSENT

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem, as well as the symptoms corrected and relieved (Corrective Care). Your doctor will weigh your needs and desires when recommending your treatment programs.

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.

- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

- I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I suspend or terminate any fees for professional services rendered to me will be immediately due and payable.

- I authorize the doctor and staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims

- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information i have provided.

Patient's Signature: _____ Date: _____

Consent to treat a minor: _____ Date: _____

☐Parent or Guardian