Allied Injury & Wellness Center, Inc.
13601 Preston Rd. Ste. W545
Dallas, Texas 75240
Phone: 214-503-9400 Fax: 214-503-9401

Patient Information & Injury History Form

Today's Date: _____ **Date of Accident:** _____

_____ ____ _____
First Name M.I. Last Name

_____
Address City State Zip Code

_____ _____
Cell Number E-mail Address

_____ Male / Female _____
Date of Birth Gender Social Security

Attorney Information:

_____
Attorney Name Attorney Phone Number

AT-FAULT Auto Insurance Company:

_____
Auto Insurance Co. Name Claim/Policy Number Insurance Co. Phone Number

YOUR Auto Insurance Company:

_____
Auto Insurance Co. Name Claim/Policy Number Insurance Co. Phone Number

MINOR CHILD'S NAME: _____ DOB: _____ AGE: _____

POSITION IN VEHICLE: □ Front Passenger □ Rear Right Passenger □ Rear Left Passenger □ Middle Rear Passenger

AREAS OF PAIN: _____

MINOR CHILD'S NAME: _____ DOB: _____ AGE: _____

POSITION IN VEHICLE: □ Front Passenger □ Rear Right Passenger □ Rear Left Passenger □ Middle Rear Passenger

AREAS OF PAIN: _____

CASE HISTORY

LIST INJURED BODY AREAS:

_____

_____

ARE YOU CURRENTLY HAVING ANY OF THE FOLLOWING SYMPTOMS?

☐ Headaches/Migraines	☐ Sleep disturbance	☐ Numbness/Tingling in arms
☐ Neck pain or stiffness	☐ Dizziness	☐ Numbness/Tingling in hands/fingers
☐ Back pain or stiffness	☐ Fatigue	☐ Numbness/Tingling in legs
☐ Knee pain – Left/Right	☐ Chest pain	☐ Numbness/Tingling in feet/toes
☐ Shoulder pain – Left/Right	☐ High Blood Pressure	
☐ Elbow pain – Left/Right	☐ Wrist/Hand pain – Left/Right	
☐ Hip pain – Left/Right	☐ Ankle/Foot pain – Left/Right	

☐ I HAVE NEVER HAD ANY OPERATIONS/SURGERIES.

DO YOU NOTICE ANY ACTIVITY RESTRICTIONS AS A RESULT OF THIS INJURY? ☐**NO** ☐**YES**
IF YES, PLEASE LIST:

_____

_____

_____

CURRENTLY TAKING ANY MEDICATION–PRESCRIPTION OR OVER-THE-COUNTER? ☐**NO** ☐**YES**

If YES, WHAT DRUGS? _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the clinic 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 clinic will be credited to my account upon 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 also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.
I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authorization for these procedures to be performed. It is understood that the X-ray negatives will remain the property of this clinic, being on file where they may be seen at any time while a patient of this clinic. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions.

Patients Signature: _____ Date: _____