STADIUM CHIROPRACTIC PC

DR. JOHN J. ARMANO

Name: (First) _____ (Last) _____ (MI) _____
Nombre *Apellido* *IN*

Adress: _____
Direccion (Street/Calle) (City/Ciudad) (State/Estado) (Zip code/ Codigo Postal)

Home Phone: _____-_____ **Work/Cell Phone:** _____-_____ **SS#** _____
Telefono del hogar *Telefono del trabajo o cellular* *# de Seguro Social*

D.O.B. _____ **Age:** _____ **Sex: Male** ( ) **Female** ( )
Fecha de Nacimiento *Edad* *Masculino* *Femenino*

Date of Accident: _____ **Time of Accident:** _____
Fecha del Accidente *Hora del Accidente*

Did you have your seatbelt on: **Yes** ( ) **No** ( )
¿Tenia usted su cinturon de seguridad? *Si* *No*

Where were you seated? _____
¿Donde estaba sentado (a)?

Where did the accident occur? _____
¿Donde ocurrio el accidente?

Year, make and model of the vehicle you were in: _____
Ano, marca y modelo del vehiculo donde estaba

Name of owner or policy holder: _____
Nombre del dueno (a) o de quien es la poliza

Name of Auto Insurance Company: _____
Nombre del seguro del auto

In your own words, please describe the accident and how much damaged was done to the car:
Es sus propias palabras describa el accidente y cuanto dano le sucedion al auto:

_____

_____

_____

_____

Did you strike any object inside the car with your body or head? Yes ( ) No ( )
¿Golpeo usted algun objeto dentro del carro con su cuerpo o cabeza?

Explain: _____
Explique:

Weather Conditions at the time of accident: **Icy** [ ] **Rainy** [ ] **Wet** [ ] **Clear** [ ] **Dark** [ ] **Other** [ ]
Condicion del tiempo *hielo* *Lluvioso* *Mojado* *Claro* *Obscuro* *Otro*

As a result of the accident you were: **Rendered unconscious** [ ] **In shock** [ ] **Dazed** [ ] **Other** [ ]
Como resultado al accidente estuvo: *Inconciente* *En shock* *Desorientado* *Otro*

Did the ambulance [ ] **or police** [ ] **arrive at the accident?** **Yes** [ ] **No** [ ]
La Ambulancia *o policia* *llego al accidente?* *Si* *No*

Did you go to the hospital? **Yes** [ ] **No** [ ] **Hospital Name:**_____
¿Fue usted al hospital? *Nombre del Hospital*

If yes, how did you get there? **Ambulance** [ ] **Other** [ ]
Si contesto si, ¿Como llego? *Ambualancia* *Otro*

Were X-Rays taken? **Yes** [ ] **No** [ ] **When were the X-rays taken?** _____
¿Le tomaron radiografias? *¿Cuando le tomaron la radiografias?*

Have you seen any other Doctor? **Yes** [ ] **No** [ ] **Doctors Name:** _____
¿Ha visto algun otro Medico? *Nombre del Medico*

Did you receive any treatment? **Yes** [ ] **No** [ ] **Medications** [ ] **Braces** [ ] **Collars** [ ]
¿Recibio usted tratamiento? *Si* *No* *Medicamentos* *Frenos* *Collar*

List all complaints in order of severity: *Nombre area de dolor en orden de gravedad*	**Have you had this before?** *¿Sufria antes de esta condicion?*	**How long ago?** *¿Hace cuanto tiempo?*
Chief Complaint: _____ *Parte del cuerpo mas afecta*	_____	_____
2nd Complaint: _____ *Segunda parte del cuerpo mas afectada*	_____	_____
3rd Complaint: _____ *Tercera parte mas afectada*	_____	_____

Have you ever had any kind of accident? **Yes** [ ] **No** [ ]
Ha tenido alguna vez cualquier clase de accidente

What kind of accident? _____ **When:** _____
¿Que tipo de accidente? *¿Cuando?*

Social History / Historia Social

Place an (x) of it applies / Marque con una (X) si le applica:

Health Conditions Checklist

Please mark an [X] to any of the conditions that apply to you.
Favor the marcar una [X] a cualquier condicion que le appliqué a usted.

	YES	NO
Allergies/*Alergias*	[ ]	[ ]
Anemia/*Anemia*	[ ]	[ ]
Arthritis/*Artritis*	[ ]	[ ]
Asthma/*Asthma*	[ ]	[ ]
Blood in Stool/ *Sangre en excreta*	[ ]	[ ]
Blood in Urine/ *Sangre en la Orina*	[ ]	[ ]
Bursitis/*Bursitis*	[ ]	[ ]
Cancer/*Cancer Type_____*	[ ]	[ ]
Chest Pain/*Dolor de Pecho*	[ ]	[ ]
Depression/*Depression*	[ ]	[ ]
Diabetes/*Diabetes*	[ ]	[ ]
Dislocation/*Dislocacion*	[ ]	[ ]
Dizziness/*Mareos*	[ ]	[ ]
Double Vision/*Doble Vision*	[ ]	[ ]
Ear Noises/*Ruidos Auditivos*	[ ]	[ ]
Epilepsy/*Epilepsia*	[ ]	[ ]
Fainting/*Desmallos*	[ ]	[ ]
Fatigue/*Fatiga*	[ ]	[ ]
Fever/*Fiebre*	[ ]	[ ]
Forgetfulness/*Olvido*	[ ]	[ ]
Gout/gota	[ ]	[ ]
Headaches/*Dolores de Cabeza*	[ ]	[ ]
Heart Condition/ *Problemas del Corazon*	[ ]	[ ]
Hepatitis/*Hepatitis Type____*	[ ]	[ ]
Hernia/*Hernia*	[ ]	[ ]
High Colesterol/ *Colesterol Alto*	[ ]	[ ]
High/Low Blood Pressure/	[ ]	[ ]
HIV/Aids/*HIV/Sida*	[ ]	[ ]
Hoarseness/*Ronquera*	[ ]	[ ]
Incontinence/*Incontinencia*	[ ]	[ ]

	YES	NO
Kidney Disease/ *Enfermedad de los Rinones*	[ ]	[ ]
Loss of Sleep/ *Persdida de Sueno*	[ ]	[ ]
Mental Illness/ *Enfermedad Mental*	[ ]	[ ]
Migraines/*Migranas*	[ ]	[ ]
Mononucleosis/*Mononucleosis*	[ ]	[ ]
Multiple Sclerosis/ *Esclerosis Multiple*	[ ]	[ ]
Nervousness/*Nerviosismo*	[ ]	[ ]
Nosebleeds/*Sangracion Nasal*	[ ]	[ ]
Numbness/*Adormecimiento*	[ ]	[ ]
Osteoporosis/*Osteoporosis*	[ ]	[ ]
Paraesthesia/*Parestesia*	[ ]	[ ]
Prostate Problems/ *Problemas de la prostate*	[ ]	[ ]
Sinuses/*Sinositis*	[ ]	[ ]
Stroke/*Derrame Celebral*	[ ]	[ ]
Spinal Disorder/ *Condiccion Espinal*	[ ]	[ ]
Swollen Joints/ *Conyonturas Hichandas*	[ ]	[ ]
Tendonitis/*Tendonitis*	[ ]	[ ]
Thrombophlebitis/ *Tromboflebitis*	[ ]	[ ]
Tubercolosis/*Tuberculosis*	[ ]	[ ]
Thyroid Condition/ *Problemas de Tiroides*	[ ]	[ ]
Vomiting/*Vomitos*	[ ]	[ ]

Other:
Otro: _____

_____

Have you ever had any surgery? ¿Alguna vez a tenido cirugia? **What type:** ¿Qué tipo? _____ **When:** ____/____/____ ¿Cuándo?

Single / Soltero (a) [ ] **Married/**Casado (a) [ ] **Divorced/** Divorciado (a) [ ]

Education _____ **Number of children:** _____
Education *numero de hijos*

Occupation: _____
Ocupacion

Employer Name & Adress: _____
Nombre y direccion del empleador

_____

_____

Have you missed time from work as a result of the accident? Yes [ ] **No** [ ]
Por causa del accidente ha perdido tiempo de su trabajo?

If yes have you returned to work? When? : _____
Si, si ¿ha regresado a trabajar? , ¿cuándo?:

Are you are pregnant? Yes [ ] **No** [ ] **Not Sure** [ ] **Last menstrual period?** _____
¿Esta embarazada? *Si* *No* *No esta segura* *Ultimo periodo menstrual*

¿Are you presently taking any medications?, describe: _____
¿Esta usted actualmente tomando algun mediacamento?

Exercise, describe: _____
Ejercicios , describa

Do you consume?
Usted consume

Tobacco [ ] **Drugs** [ ] **Alcohol** [ ] **Caffeinated Beverages** [ ]
Tabacco *Drogas* *Alcohol* *Bebidas cafeinada*

Do you have a family physician? Yes [ ] **No** [ ]
¿Tiene un medico de familia?

If yes please give name and adress: _____
Nombre y direccion

_____

_____

_____

Do you have an Attorney? **Yes** [ ] **No** [ ] **If yes fill in the information below:**
¿Tiene un abogado? *Si* *No* *Si contesta si, favor de llenar lo siguiente:*

Attorney's Name: _____ **Tel. #** _____-_____
Nombre de abogado

Address: _____ **Fax #** _____-_____
Direccion

_____

_____

Patient's Signature _____ **Date** _____
Firma del paciente *Fecha*

Parent/ Guardian Signature _____ **Date** _____
Firma del padre or guardian *Fecha*

Witness Signature _____ **Date** _____
Firma de testigo *Fecha*