Personal Injury Patient Information

Name _____ Date _____ E-Mail _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Birthdate _____ Age _____ Sex _____

SS# _____ Emergency Contact Name/Number _____

Date of Accident_____ Time _____ AM/PM Approx. Damage of your car $_____

Year & Model of **your** car_____ Year & Model of **other** car _____

Where were you seated? _____ Were you wearing a seatbelt? _____

Speed of your car? _____ mph The other car: _____ mph City/State of accident _____

Type of Collision: [ ]Head-on [ ]Broad-side [ ]Front Impact [ ]Rear-end car in front [ ]Rear Impact

In your own words, please describe the accident: _____

_____

At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car: _____

Describe how you felt immediately after the accident: _____

_____

Later that day: _____

The next day: _____

Did you get any bleeding cuts? [ ] Yes [ ] No If yes, where? _____

Did you get any bruises? [ ] Yes [ ] No If yes, where? _____

Did you seek medical help immediately after the accident: Yes / No Taken by an ambulance? Yes / No

If yes, please explain: _____

Name of Doctor/Hospital: _____ Last Date of Treatment: _____

List any medications you are currently taking: _____

Have you missed time from work: [ ] Yes [ ]No If yes, how many days? _____

Occupation: _____ Employer: _____

Are you pregnant? [ ] Yes [ ] No How far along? _____ Due Date _____

Have you ever seen a chiropractor? [ ] Yes [ ] No If yes, how long ago? _____

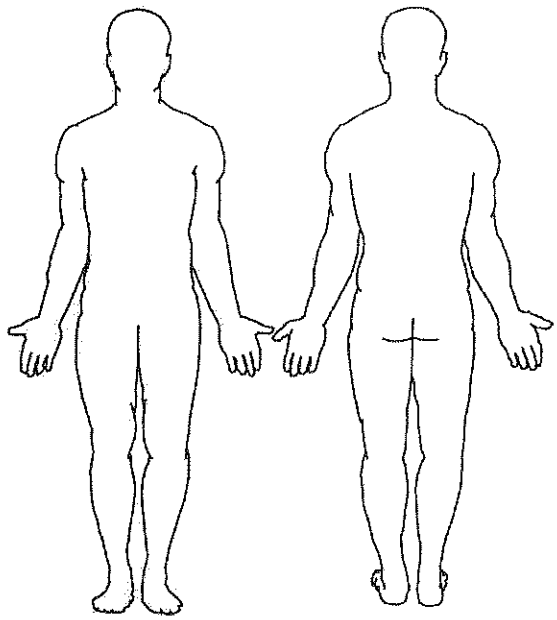
Check symptoms and/or current chief complaints apparent since the accident:

[ ] Neck Pain	[ ] Upper Back Pain	[ ] Mid Back Pain	[ ] Low Back Pain	[ ] Pelvis
[ ] Shoulder R / L	[ ] Arm R / L	[ ] Elbow R / L	[ ] Forearm R / L	[ ] Wrist R / L
[ ] Hand R / L	[ ] Hip R / L	[ ] Thigh R / L	[ ] Knee R / L	[ ] Leg R / L
[ ] Ankle R / L	[ ] Foot R / L	[ ] Headache	[ ] Fainting	[ ] Cold Sweats
[ ] Cold Feet	[ ] Cold Hands	[ ] Chest Pain	[ ] Fatigue	[ ] Facial Pain
[ ] Constipation	[ ] Diarrhea	[ ] Light Sensitivity	[ ] Shortness of Breath	[ ] Ringing
[ ] Loss of Smell	[ ] Loss of Taste	[ ] Loss of Memory	[ ] Loss of Balance	[ ] Dizziness

[ ] Anxious/Nervous [ ] Pain Behind Eyes [ ] Numbness in Toes [ ] Numbness in Fingers

[ ] Sleeping Problems [ ] Clicking/Popping of Jaw Other: _____

Please mark the areas of your body where you feel the described pain:



Front Back

For Doctors Use only

SUBJECTIVE PAIN LEVEL

On a scale of 1- 10, place an X in your current pain level: (1 - minimal pain, 10 - extreme pain)

[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
1	2	3	4	5	6	7	8	9	10

PLACE AN (X) NEXT TO THE SYMPTOMS THAT YOU HAVE:

GENITO-URINARY SYSTEM

[ ] Bladder Trouble [ ] Excessive Urination [ ] Scanty Urination [ ] Painful Urination

GASTRO-INTESTINAL SYSTEM

[ ] Poor Appetite [ ] Excessive Hunger [ ] Excessive Thirst [ ] Nausea

[ ] Difficulty Chewing [ ] Difficulty Swallowing [ ] Vomiting Food [ ] Abdominal Pain

[ ] Diarrhea [ ] Constipation [ ] Black Stool [ ] Bloody Stool

[ ] Hemorrhoids [ ] Liver Trouble [ ] Weight Trouble [ ] Gall Bladder Trouble

NERVOUS SYSTEM

[ ] Numbness [ ] Loss of Feeling [ ] Paralysis [ ] Dizziness

[ ] Fainting [ ] Headaches [ ] Convulsions [ ] Muscle Jerking

[ ] Forgetfulness [ ] Confusion [ ] Depression

CARDIO-VASCULAR SYSTEM

[ ] Chest Pain [ ] Pain over Heart [ ] Difficulty Breathing [ ] Persistent Cough

[ ] Coughing Blood [ ] Coughing Phlegm [ ] Rapid Heartbeat [ ] High Blood Pressure

[ ] Heart Problems [ ] Lung Problems [ ] Varicose Veins [ ] Other_____

EYES, EARS, NOSE AND THROAT SYSTEM

[ ] Eye Strain [ ] Eye Inflammation [ ] Vision Problems [Breathing Difficulty

[ ] Ear Pain [ ] Ear Noises [ ] Hearing Loss [ ] Speech Difficulty

[ ] Nose Bleeding [ ] Nose Discharge [ ] Nose Pain [ ] Dental Problems

[ ] Sore Gums [ ] Sore Mouth [ ] Sore Throat [ ] Hoarseness

ACTIVITIES OF DAILY LIVING ASSESSMENT

Directions: This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please check one item in each section which most closely applies to you.

SECTION 1: PAIN INTENSITY

[ ] I can tolerate the pain I have without using pain killers.

[ ] The pain is bad but I manage without pain killers.

[ ] Pain killers give no relief from pain. I do not use them.

[ ] Pain killers give complete relief from pain.

[ ] Pain killers give moderate relief from pain.

[ ] Pain killers give very little relief from pain.

SECTION 2: PERSONAL CARE

[ ] I can look after myself normally without causing extra pain.

[ ] I can look after myself normally but it causes extra pain.

[ ] It is painful to look after myself and I am slow and careful.

[ ] I need some help but manage most of my personal care.

[ ] I need help every day in most aspects of self-care.

[ ] I do not get dressed, wash with difficulty, and stay in bed.

SECTION 3: LIFTING

[ ] I can lift heavy weights without extra pain.

[ ] I can lift heavy weights but it causes extra pain.

[ ] I can lift only very light weights.

[ ] I cannot lift or carry anything at all.

[ ] Pain prevents me from lifting heavy weights off the floor, but I can manage if they care conveniently positioned (on a table).

[ ] Pain prevents me from lifting heavy weights. I can manage light to medium weights if they are conveniently positioned.

SECTION 4: WALKING

[ ] Pain does not prevent me from walking any distance.

[ ] Pain prevents me from walking more than one mile.

[ ] Pain prevents me from walking more than ¼ mile.

[ ] I can only walk using a cane or crutches.

[ ] Pain prevents me from walking more than ½ mile.

[ ] I am in bed most of the time.

SECTION 5: SITTING

[ ] I can sit in any chair as long as I like.

[ ] Pain prevents me from sitting for more than 1 hour.

[ ] Pain prevents me from sitting for more than 10 minutes.

[ ] I can only sit in my favorite chair as long as I like.

[ ] Pain prevents me from sitting for more than 30 minutes.

[ ] Pain prevents me from sitting at all.

SECTION 6: STANDING

[ ] I can stand as long as I want without extra pain.

[ ] Pain prevents me from standing for more than 30 minutes.

[ ] I can stand as long as I want but it causes extra pain.

[ ] Pain prevents me from standing for more than 1 hour.

[ ] Pain prevents me from standing for more than 10 minutes.

[ ] Pain prevents me from standing at all.

SECTION 7: SLEEPING

[ ] Pain does not prevent me from sleeping.

[ ] Even when I take medication, I sleep less than 4 hours.

[ ] I can sleep well only by taking medication.

[ ] Even when I take medication, I sleep less than 6 hours.

[ ] Even when I take medication, I sleep less than 2 hours.

[ ] Pain prevents me from sleeping at all.

SECTION 8: SEX LIFE

[ ] My sex life is normal and causes no extra pain.

[ ] My sex life is severely restricted by pain.

[ ] My sex life is normal but causes some extra pain.

[ ] My sex life is nearly absent because of pain.

[ ] My sex life is nearly normal but is very painful.

[ ] Pain prevents any sex life at all.

SECTION 9: SOCIAL LIFE

[ ] My social life is normal and gives me no extra pain.

[ ] Pain has restricted my social life and I do not go out as often.

[ ] My social life is normal but increases the degree of pain.

[ ] Pain has no significant effect on my social life apart from limiting my more energetic interests.

[ ] Pain has restricted my social life to my home.

[ ] I have no social life because of pain.

SECTION 10: TRAVELING

[ ] I can travel anywhere without extra pain.

[ ] I can travel anywhere but it gives me extra pain.

[ ] Pain is bad but I manage journeys over 2 hours.

[ ] Pain restricts me to the journeys of less than 1 hour.

[ ] Pain restricts me to short necessary trips under ½ hour.

[ ] Pain restricts me from traveling, except to the doctor or hospital.

INFORMED CONSENT TO CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of procedures which are within the scope of practice of chiropractic including, but limited to, chiropractic adjustments, various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic named below.

I understand that, as in the practice of medicine, and in the practice of other clinical therapies there are some risks to treatment. I understand that if I receive chiropractic treatments the most common risks are temporary aggravation of my condition or soreness. Rarer risks include, but are not limited to fractures, strokes, dislocations, sprains, and aggravation of disc injuries.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and are in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I _____ have read and fully understand the above statements.

(Print Name)

_____ _____

(Signature) (Date)

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CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I,_____being the parent or legal guardian of_____

(Print Name) (Print Child's Name)

have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____

(Signature) (Date)

Driver's Auto Insurance_____ Claim #_____

Adjuster's Name _____ Contact # _____

Other Party's Insurance_____ Claim #_____

Adjuster's Name_____ Contact # _____

Attorney's Name _____

Contact # _____ Fax # _____

Address _____

Third Party Agreement

Our office handles automobile accident claims three ways. The first is to bill the Medpay portion of the auto insurance of the vehicle the patient was in during the accident. In the event that the charges exceed the allowed amount on the Medpay policy the patient accepts responsibility of any remaining balance. The second is if you retain an attorney and you and the attorney sign a lien agreeing to pay your medical bills **in full** when settlement is reached.

The last way is if there is no Medpay and no attorney then we will wait until you settle with the third party insurance (the other person's insurance). This makes you responsible to negotiate your settlement to include your medical bills. When settlement is reached the patient must forward payment in full directly to our office. The third party insurance **will not pay us directly**. During the course of treatment you will receive updated billings to keep you informed of your balance. If a settlement is not reached within three months of your final date of service, you will be required to make payment on your account.

_____

Patient Signature

_____

Date