Personal Injury Patient Information

Name: ______________________________ Date: ______________

Birthdate: ______ /______ /______ Age: ________ Gender: _____ SSN: ______ - ______ - ______

Phone: ____________________ Email: ______________________________

Address: ________________________ City: ______________ Zip code: __________

Emergency contact: ________________________ Phone: ________________

Date of accident: _____ /_____ /_____ Time: _______ am/pm Damage of your car: $__________

Year & model of your car: ______________ Year & model of the other car: ______________

Where were you seated? ______________ Were you wearing a seatbelt? Yes | No

Speed of your car: ______ mph 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, what parts of your head or body hit which parts on the inside of your car?

____

Describe how you felt immediately after the accident: ______________________________

____

Later that day: ____

The next day: ____

Did you have any bleeding cuts? Yes | No If yes, where? ____________________

Did you receive any bruises? Yes | No If yes, where? ____________________

Did you seek medical help immediately after? Yes | No Taken by ambulance? Yes | No

If yes, please explain: ____

Name of doctor/hospital: ____________________ Last date of treatment: ______________

Current medications: ____

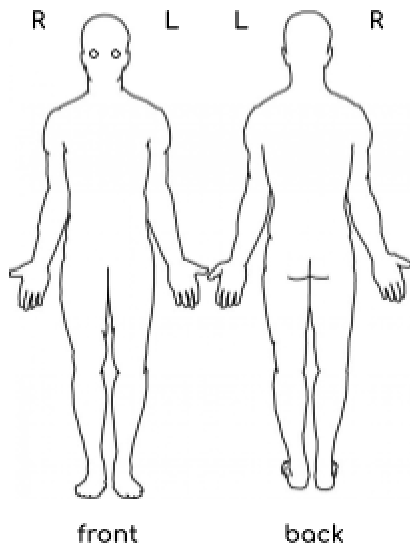
Have you missed time from work? Yes | No If yes, how many days? ______________

Occupation: ________________________ Employer: ____________________

Are you pregnant? Yes | No If yes, how far along? ______ weeks Due date: ____ /____ /____

Have you ever seen a chiropractor? Yes | No If yes, how long ago? ________________

Please mark on the picture where you have pain, and rate your pain on a scale of 1 to 10 (extreme): ______



For Doctor's use only

Please circle the current symptoms and primary complaints apparent since the accident:

Neck pain	Arm R / L	Elbow R / L	Light sensitivity	Facial pain
Upper back pain	Hand R / L	Headache	Pain behind eyes	Clicking jaw
Mid back pain	Hip R / L	Fainting	Sleeping problems	Numb hands
Low back pain	Thigh R / L	Dizziness	Shortness of breath	Numb toes
Pelvis	Knee R / L	Fatigue	Loss of memory	Cold hands
Shoulder R / L	Leg R / L	Chest pain	Loss of taste	Cold feet
Wrist R / L	Foot R / L	Diarrhea	Loss of smell	Cold sweats

Please check the symptoms that you have had as a result of the accident:

Genitourinary:	◯ Excessive urination	◯ Bladder issues	◯ Scanty urination	◯ Painful urination
Gastrointestinal:	◯ Poor appetite	◯ Diarrhea	◯ Hemorrhoids	◯ Excessive hunger
	◯ Gallbladder issues	◯ Constipation	◯ Nausea	◯ Excessive thirst
	◯ Difficulty swallowing	◯ Black stool	◯ Vomiting	◯ Abdominal pain
	◯ Difficulty chewing	◯ Bloody stool	◯ Liver trouble	◯ Weight issues
Nervous system:	◯ Numbness	◯ Fainting	◯ Headaches	◯ Forgetfulness
	◯ Loss of feeling	◯ Dizziness	◯ Depression	◯ Muscle jerking
	◯ Paralysis	◯ Confusion	◯ Anxiety	◯ Convulsions
Cardiovascular:	◯ High blood pressure	◯ Persistent cough	◯ Rapid heartbeat	◯ Varicose veins
	◯ Coughing blood	◯ Heart problems	◯ Pain over heart	◯ Chest pain
	◯ Coughing phlegm	◯ Lung problems	◯ Short of breath	◯ Other: __________
Eyes, ears, nose, & throat:				
	◯ Eye strain	◯ Ear pain	◯ Nose bleeding	◯ Dental problems
	◯ Eye inflammation	◯ Ear noises	◯ Nose discharge	◯ Sore gums
	◯ Vision problems	◯ Hearing loss	◯ Nose pain	◯ Sore mouth
	◯ Difficulty breathing	◯ Speech issues	◯ Hoarseness	◯ Sore throat

Activities of Daily Living Assessment

Section 1: Pain Intensity

- ◯ I can tolerate the pain without painkillers
- ◯ The pain is bad, but I manage without painkillers
- ◯ Painkillers give no relief from pain, I don't use them
- ◯ Painkillers give very little relief from pain
- ◯ Painkillers give moderate relief from pain
- ◯ Painkillers give complete relief from pain

Section 2: Personal Care

- ◯ It causes me no pain to take care of myself
- ◯ I need some help, but I can mostly manage
- ◯ I'm careful taking care of myself as it's painful
- ◯ It causes extra pain to take care of myself
- ◯ I need help daily in most aspects of care
- ◯ I don't get dressed or wash up, I stay in bed

Section 3: Lifting

- ◯ I can lift heavy weights without extra pain
- ◯ I can lift heavy weights, but it causes me pain
- ◯ I can lift heavy weights if conveniently placed
- ◯ I can lift light to medium weights
- ◯ I can only lift very light weights
- ◯ I cannot lift anything at all

Section 4: Walking

- ◯ I can walk any distance without pain
- ◯ I can't walk more than 1 mile without pain
- ◯ I can't walk more than ½ mile without pain
- ◯ I can't walk more than ¼ mile without pain
- ◯ I can only walk with a cane or crutches
- ◯ I'm in bed most of the time

Section 5: Sitting

- ◯ I can sit in any chair as long as desired
- ◯ I can only sit in my favorite chair as long desired
- ◯ I can't sit for more than 1 hour without pain
- ◯ I can't sit for more than ½ hour without pain
- ◯ I can't sit for more than 10 minutes
- ◯ I can't sit at all without pain

Section 6: Standing

- ◯ I can stand as long as desired without pain
- ◯ I can stand as long as desired, but it causes pain
- ◯ I can't stand for more than 1 hour without pain
- ◯ I can't stand for more than ½ hour
- ◯ I can't stand for more than 10 minutes
- ◯ I can't stand at all without pain

Section 7: Sleeping

- ◯ Pain doesn't prevent me from sleeping
- ◯ I can only sleep by taking medication
- ◯ Even with medication, I sleep less than 2 hours
- ◯ With medication, I sleep less than 4 hours
- ◯ With medication, I sleep less than 6 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 normal, but causes some extra pain
- ◯ My sex life is nearly normal, but very painful
- ◯ My sex life is severely restricted by pain
- ◯ My sex life is nearly absent due to pain
- ◯ Pain prevents any sex life at all

Section 9: Social Life

- ◯ My social life is normal and causes no extra pain
- ◯ My social life is normal, but causes some extra pain
- ◯ Pain only limits my more energetic interests
- ◯ Pain restricts my social life, I go out less
- ◯ Pain has restricted my social life to home
- ◯ I have no social life due to pain

Section 10: Traveling

- ◯ I can travel anywhere without extra pain
- ◯ I can travel anywhere, but it causes extra pain
- ◯ I can't manage journeys more than 2 hours
- ◯ Pain restricts me to trips less than 1 hour
- ◯ Pain restricts me to trips less than ½ hour
- ◯ Pain prevents traveling except to the doctor

Insurance & Attorney Information (if applicable)

Driver's auto insurance: ______________________________ Claim #: ______________________________

Adjuster's name: ______________________________ Phone: ______________________________

Other party's insurance: ______________________________ Claim #: ______________________________

Adjuster's name: ______________________________ Phone: ______________________________

Attorney's name: ______________________________ Phone: ______________________________

Address: ____

Third Party Agreement

Our office handles automobile accident claims in three ways:

1) If you have Medpay (Medical Payment) on the automobile insurance for the vehicle you were in during the accident, we can bill them for your treatment. In the event that the charges exceed the limit on your policy, you will then accept full responsibility of the remaining balance. If you have Medpay, you are hereby assigning all benefits and payments directly our office. Further, you are authorizing the use of your signature on all claim submissions, and to the use of your healthcare information to obtain payment and determine insurance benefits from your insurance company and its agents.

2) If you retain an attorney, you and the attorney are required to sign a lien agreeing to pay your medical bills in full when a settlement is reached. If at any time during treatment your attorney no longer represents your case, you will then be financially responsible for your balance at our office.

3) If you do not have Medpay on your automobile insurance policy and do not wish to be represented by an attorney, you may pay our time of service fee for treatment at our office. For adults, the reduced "Time of Service Fee" is $80.00 for the initial exam and $45.00 for subsequent visits. For students who are currently in high school or younger, as well as seniors who are 65 years of age and over, the price is $60.00 for the initial exam and $35.00 for following visits. You are being given a reduced fee which you are agreeing to pay at the time service is rendered. X-RAYS ARE AN ADDITIONAL CHARGE IF NEEDED.

Signature: ______________________________ Date: ______________________________

Informed Consent to Chiropractic Treatment and Care

I hereby request and consent to the performance of procedures within the scope of the practice of chiropractic, including, but not limited to chiropractic adjustments, various modes of physical therapy (including Pulsed Electromagnetic Field Therapy), and diagnostic x-rays for myself (or the patient for whom I am legally responsible) by Dr. Kenneth M. Toy. I understand that, as in the practice of medicine and other clinical therapies, there are some risks to treatment, including, but not limited to temporary aggravation of my condition or soreness. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on his judgment during the course of my treatment regarding what he feels will be most profitable and effective, with my best interests in mind.

Signature: ____ Date: ___________________________

Price Acknowledgment and Past Due / Collection Agreement

I acknowledge that all payments are due at the time of service, unless prior payment arrangements have been made. In the event that my account has an outstanding balance that exceeds 30 days with no contact from me, my account will be forwarded to American Capital Ent. Inc., a collections agency.

◯ **Billing insurance**: I certify that I and/or my dependent have coverage and assign all insurance benefits and payments directly to Dr. Kenneth M. Toy, including any that may be issued to me by my insurance company for services rendered. I understand that I am responsible for any and all deductibles, copays, coinsurances, and non-covered services.

◯ **Not billing insurance**: the initial adult exam is $80.00 and subsequent visits are $45.00. The initial exam is $60.00 and subsequent visits are $35.00 for students in high school or younger, as well as seniors who are 65 years of age and over. If a year has passed between visits, there will be a re-exam fee of $60.00 for adults and $50.00 for seniors and students. X-RAYS ARE AN ADDITIONAL CHARGE IF NEEDED.

Signature: ____ Date: ___________________________

Pregnancy Release (if applicable)

To the best of my knowledge, I am not pregnant. The doctor has my permission to perform an x-ray evaluation which can be hazardous to an unborn child. Date of last menstrual period: ___________

Signature: ____ Date: ___________________________

Authorization for the Release of Medical Records (if desired)

I consent to the release of any and all medical records for services rendered at Dr. Toy Chiropractic. I understand that my records may include sensitive materials, that I may revoke this authorization at any time, and that the revocation will not apply to my insurance company when contesting a claim.

Signature: ____ Date: ___________________________