MOTOR VEHICLE ACCIDENT HISTORY

PATIENT NAME:			DATE:
ADDRESS:		CITY:	STATE/ZIP CODE:
HOME PHONE NUMBER:		CELL PHONE NUMBER:	
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	AGE:	GENDER:
EMERGENCY CONTACT NAME:		EMERGENCY CONTACT PHONE NUMBER:	
EMPLOYER NAME:		EMPLOYER ADDRESS:	

ACCIDENT INFORMATION

DATE OF ACCIDENT:	TIME OF ACCIDENT:	WHERE WERE YOU LOCATED IN THE VEHICLE AT THE TIME OF THE ACCIDENT? ❑ DRIVER ❑ PASSENGER ❑ FRONT SEAT ❑ BACK SEAT
NUMBER OF PEOPLE IN THE CAR:	WERE YOU WEARING A SEATBELT?	
WHAT DIRECTION WAS YOUR CAR HEADED? ❑ NORTH ❑ SOUTH ❑ EAST ❑ WEST		ON WHAT STEET WERE YOU HEADED?
WHAT DIRECTION WAS THE OTHER CAR HEADED? ❑ NORTH ❑ SOUTH ❑ EAST ❑ WEST		WERE YOU STRUCK FROM: ❑ BEHIND ❑ FRONT ❑ LEFT SIDE ❑ RIGHT SIDE
WERE YOU KNOCKED UNCONSCIOUS? ❑ YES ❑ NO		DID YOU HIT YOUR HEAD? ❑ YES ❑ NO
WHERE WERE YOU TAKEN AFTER THE ACCIDENT?		BY AMBULANCE: ❑ YES ❑ NO
WERE THE POLICE ON THE SCENE? ❑ YES ❑ NO	WAS A REPORT FILED? ❑ YES ❑ NO	DO YOU HAVE A COPY? ❑ YES ❑ NO
HAVE YOU BEEN TREATED BY ANY OTHER DOCTORS FOR THIS ACCIDENT? ❑ YES ❑ NO		SINCE THE INJURY, ARE YOUR SYMPTOMS: ❑ IMPROVING ❑ GETTING WORSE ❑ GETTING BETTER
HAVE YOU LOST TIME FROM WORK? ❑ YES ❑ NO		DATE YOU LEFT WORK: / DATE YOU RETURNED TO WORK:
HAVE YOU BEEN INVOLVED IN AN ACCIDENT IN THE PAST? ❑ YES ❑ NO		IF YES, PLEASE DESCRIBE:
DO YOU HAVE ANY PREVIOUS ILLNESSES WHICH RELATE TO THIS CASE? ❑ YES ❑ NO		IF YES, PLEASE DESCRIBE:
DO YOU HAVE ANY ACTIVITY RESTRICTIONS AS A RESULT OF THIS INJURY? ❑ YES ❑ NO		IF YES, PLEASE DESCRIBE:

INSURANCE INFORMATION

AUTO INSURANCE COMPANY NAME:	
ADJUSTER NAME:	ADJUSTER PHONE NUMBER:
POLICY NUMBER:	CLAIM NUMBER:

ACCIDENT INFORMATION

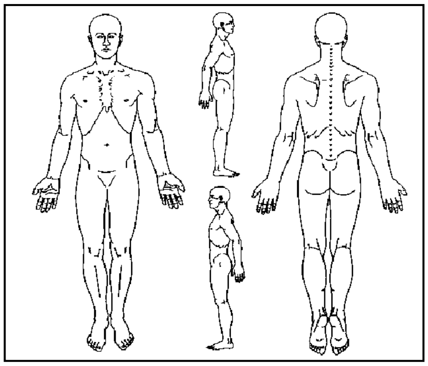
EXPLAIN THE ACCIDENT IN YOUR WORDS:

INSTRUCTIONS: *Check (✓) any/all symptoms noted after the accident.*

- ❑ HEADACHE
- ❑ NECK PAIN
- ❑ NECK STIFFNESS
- ❑ SLEEPING PROBLEMS
- ❑ BACK PAIN
- ❑ NERVOUSNESS
- ❑ TENSION
- ❑ IRRITABILITY
- ❑ CHEST PAIN
- ❑ DIARRHEA
- ❑ CONSTIPATION
- ❑ FEVER
- ❑ DIZZINESS
- ❑ HEAD SEEMS HEAVY
- ❑ PINS & NEEDLES IN ARMS
- ❑ PINS & NEEDLES IN LEGS
- ❑ NUMBNESS IN FINGERS
- ❑ NUMBNESS IN TOES
- ❑ SHORTNESS OF BREATH
- ❑ FATIGUE
- ❑ DEPRESSION
- ❑ FEET FEEL COLD
- ❑ HANDS FEEL COLD
- ❑ COLD SWEATS
- ❑ LIGHT BOTHERS EYES
- ❑ LOSS OF MEMORY
- ❑ EARS RING
- ❑ FACE FLUSHED
- ❑ RINGING IN EARS
- ❑ LOSS OF BALANCE
- ❑ FAINTING
- ❑ LOSS OF SMELL
- ❑ TROUBLE SWALLOWING
- ❑ UPSET STOMACH
- ❑ OTHER: ______________
- ❑ OTHER: ______________

INTRUCTIONS: *Please mark the area and type of pain on the drawings using the codes listed below:*

N=Numbness P=Pain A=Ache T=Tingling S=Stiffness/Soreness



COMMENTS:

____

____

____

____

____

PLEASE PROVIDE ANY OTHER PERTINENT INFORMATION YOU THINK WE SHOULD KNOW:

DOCTOR ONLY

DOCTOR COMMENTS:

SIGNATURE

PATIENT SIGNATURE:	DATE:

AUTHORIZATION FOR CARE / TERMS OF ACCEPTANCE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting 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.

As with any healthcare procedure, there are certain risks which may arise during chiropractic care. We will make ever reasonable effort during the examination to screen for contraindications to care; if you have a condition that would otherwise come to my attention, it is YOUR responsibility to inform the doctor.

Ownership of X-ray Films: *It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.*

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment..

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Out chiropractic method of correction is by specific adjustments to the spine.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of the nerve function and interference of the transmission of the nerve impulses, lessening the body's innate ability to maintain maximum health.

We do not offer to diagnose or treat any disease or condition other than the vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

SIGNATURE:	DATE:
GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE:	DATE:

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

❑ PATIENT ❑ SPOUSE ❑ PARENT ❑ WORKERS COMP ❑ AUTO INSURANCE ❑ MEDICARE ❑ HEALTH INSURANCE

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE:

ADDITIONAL NOTES:

Family First Chiropractic

Personal Injury Form

Patient Name: ___________________________________

Date of Accident: ___________________________________

PATIENT'S INFORMATION

Patient's Car Insurance: ____

Claim #: ____

Policy #:____

Adjuster's Name: ____

Adjuster's Number: ____

AT FAULT PARTY'S INFORMATION

Car Insurance Information: ____

____

Claim #: ____

Policy #:____

Adjuster's Name: ____

Adjuster's Number: ____

ATTORNEY CONTACT INFORMATION (if applicable)

Attorney's Name: ____

Attorney's Number: ____

Attorney's Address: ____

Car Damage Amount: __$____________

- **Please bring in <u>YOUR</u> car insurance card, so that we may make a copy for our records.**
- **If not reported, REPORT IT!**

FINANCIAL AGREEMENT
PERSONAL INJURY

We would like to take a moment to welcome you to our Center and to assure you will receive the very best care available for your injury. In order to familiarize you with the financial policy of our Center, I would like to explain how you medical bills will be handled.

PARTY RESPONSIBLE:
If you were involved in an auto accident in your own vehicle, we will bill the medical payments portion or Personal Injury Protection portion of you insurance policy to cover the treatment chargers incurred in out Center.

MED PAY: If you were a passenger in another vehicle, the insurance company that insures the automobile may be billed for your medical services incurred.
PIP: If you were a passenger in another vehicle, and you own a car that has PIP coverage, the insurance company that carries your policy will be responsible to pay you medical bills.
3rd PARTY: If another vehicle has caused the accident, we will first bill you automobile MedPay or PIP policy for coverage PRIOR to submitting a claim to the insurance carrier of the party at fault.

It is also to your advantage for our Center to bill you own health insurance policy for you medical services, providing your policy does not state otherwise. Any amount received above/beyond your total bill in this office will be refunded to you.

ATTORNEY LIENS:
If you hire an attorney to represent you in a lawsuit, it is our policy to have your attorney sign a Doctor's Lien. This will guarantee direct payment to our Center for any unpaid balance upon the settlement of your case. We retain the right to first submit all charges to your private and/or auto insurance policy for payment. Further, this Center does not discount or reduce the amount of your balance based upon the outcome of your settlement.

RESPONSIBILITY FOR PAYMENT:
As a courtesy to you, we will gladly submit your charges to your insurance company(s) and/or your attorney; however, all services rendered at this Center are charges directly to you, and ultimately, you are personally responsible for payment of these charges, regardless of any insurance reimbursement or settlement you may or may not receive.
The Center specializes in the care of Personal Injury patients, so it is very important for you to follow our recommendations and to keep your scheduled appointments with this Center in order to achieve maximum benefit for your injury.   If you choose not to receive the care that is necessary for treatment of you injury, your Personal Injury case will be closed, the insurance company (ies) and/or attorney will be immediately notified and payment for your total account balance will be due within 10 business days.

Once again, we welcome you to our Center. We hope that this has answered any questions that you might have about our financial arrangements. If, at any time you have further questions about your care, please don't hesitate to ask.

I have read and agree to the above.

CLIENT___________________________________ DATE____________________________

WITNESS_________________________________ DATE____________________________

Complaint History Form

Patient's Name: ___________________________________ Date:______________

Location of Complaint(s):
Complaint(s) begin when & how?
Check the quality if the complaint: □ Dull □ Sharp □ Aching □ Burning □ Shooting Pain □ Nagging □ Throbbing □ Other
Any numbness/tingling anywhere in your body? Where?
Does the complaint/pain travel?
Grade Intensity/Severity: 0 1 2 3 4 5 6 7 8 9 10 (0= no complaint/ 10 = worst possible pain/complaint imaginable)
Has this condition: □ Gotten Worse □ Stayed Constant □ Come and Gone
Does this condition interfere with: □ Work □ Sleep □ Daily Routine □ Other Activities Please explain:
Has this condition occurred before? □ Yes □ No Please Explain:
Have you seen other doctor's for this condition? □ Yes □ No
Doctor's Name
Type of treatment:
If job related, have you made a report of your accident to your employer? □ Yes □ No

Functional Rating Index

For each item below, please circle the number which most closely describes your condition right now.

1) Pain Intensity

0- No Pain	1- Mild Pain	2- Moderate Pain	3- Severe Pain	4- Worst Possible Pain

2) Sleeping

0- Perfect Sleep	1- Mildly Disturbed	2- Moderately Disturbed	3- Greatly Disturbed	4- Totally Disturbed Sleep

3) Personal Care (washing, dressing, etc.)

0- No Pain No Restrictions	1- Mild Pain; No Restrictions	2- Moderate Pain; Go Slowly	3- Moderate Pain; Some Assistance	4- Severe Pain; 100% Assistance

4) Travel (driving, etc.)

0- No Pain on Long Trips	1- Mild Pain on Long Trips	2- Moderate Pain on Long Trips	3- Moderate Pain on Short Trips	4- Severe Pain on Short Trips

5) Work

0- Usual Work + Extra	1- Usual Work, No Extra	2- 50% of Usual Work	3- 25% of Usual Work	4- Cannot Work

6) Recreation

0- All Activities	1- Most Activities	2- Some Activities	3- Few Activities	4- No Activities

7) Frequency of Pain

0- No Pain	1- Occasional (25%)	2- Intermittent (50%)	3- Frequent (75%)	4- Constant (100%)

8) Lifting

0- No Pain with Heavy Weight	1- Increased Pain with Heavy Weight	2- Increased Pain with Moderate Weight	3- Increased Pain with Light Weight	4- Increased Pain with Any Weight

9) Walking

0- No Pain with Any Distance	1- Increased Pain after 1 Mile	2- Increased Pain after ½ Mile	3- Increased Pain after ¼ Mile	4- Increased Pain after Any Distance

10) Standing

0- No Pain with Any Time	1- Increased Pain after Several Hours	2- Increased Pain after 1 Hour	3- Increased Pain after ½ Hour	4- Increased Pain after Any Time

Total __________ (/4, X10) = Functional Rating Score __________%

Patient or Guardian (Print Name) ____

Patient or Guardian Signature____Date_____________________

Treating Doctor Signature ____ Date_____________________