ACCIDENT/INJURY QUESTIONNAIRE

Name: (Last, First MI)_____ **Today's Date:** _____

AUTOMOBILE ACCIDENT – ADDITIONAL INFORMATION

- **Was anyone else in the vehicle with you?** ☐ **No** ☐ **Yes -** *(Number of people)* _____
- **You were?** ☐ **Front seat** – *Driver / Passenger* ☐ **Rear Seat**– Behind Driver / Middle / Behind Passenger / 2nd Row / 3rd Row
- **Name of Driver**, *if not self*: _____ **Name of Driver of other vehicle:** _____
- **Did airbags deploy?** ☐ **No** ☐ **Yes** **Did Police arrive?** ☐ **No** ☐ **Yes** **Using Seatbelt?** ☐ **No** ☐ **Yes**
- **Did you strike the windshield or object in car?** ☐ **No** ☐ **Yes** - *(Describe)* _____
- **Were you knocked unconscious?** ☐ **No** ☐ **Yes** *(How long?)* _____
- **Where was your vehicle impacted?** Front / Rear / Passenger Side / Driver's Side / Other: _____
- **Where was the other vehicle impacted?** Front / Rear / Passenger Side / Driver's Side / Other: _____
- **Your Auto Ins:** _____ **Policy #:** _____ **Claim #:** _____ **Phone #:**_____
  - **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____
- **Other's Auto Ins:** _____ **Policy #:** _____ **Claim #:** _____ **Phone #:**_____
  - **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

WORKER'S COMPENSATION INJURY – ADDITIONAL INFORMATION

Employer: _____ **Occupation:** _____ **Claim #:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Contact Person: _____ **Phone:** _____ **Email:** _____

GENERAL ACCIDENT/INJURY INFORMATION – (*PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED*)

Date of Accident: ____/____/_____ **Time**: ___:_____ AM / PM

Please describe the accident in as much detail as possible? _____

_____

_____

_____

Before the accident/injury:

- **Have you ever had any complaints in the involved area before?** ☐ **No** ☐ **Yes**
  - *If yes* - **Were they present at the time of the accident/injury?** ☐ **No** ☐ **Yes**
    - *If yes* - **Summarize these complaints prior to the accident:** _____
- **Were you capable of performing all of your work activities without restriction?** ☐ **No** ☐ **Yes**

At the time of the accident/injury:

- **Did you feel pain immediately after the accident?** ☐ **No** ☐ **Yes** ☐ **Later that day** ☐ **Next day** ☐ **When?** _____
- **Were you taken anywhere after the accident?** ☐ **No** ☐ **Yes** ☐ **Later that day** ☐ **Next day** ☐ **When?** _____
  - *If yes,* **How?**_____ **Where?**_____
  - *If yes,* **Did you receive treatment?** ☐ **No** ☐ **Yes -** *(Describe)* _____

Since the accident/injury:

- **Are your symptoms:** ☐ **Improving?** ☐ **Getting Worse?** ☐ **The Same?**
- **Are your work activities restricted as a result of this accident/injury?** ☐ **No** ☐ **Yes** - *(How?)* _____
- **Have you missed any work since this accident?** ☐ **No** ☐ **Yes -** *(Dates?)* _____
- **Have you retained an Attorney?** ☐ **No** ☐ **Yes - Name:**_____ **Phone:** _____
  - **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

Patient No: _____

PATIENT CASE INFORMATION

Date: _____ **Patient No:** _____

Patient Information

Name:*(First MI Last)* _____ **Preferred Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Cell Phone: _____ **Cell Carrier:** _____ **Home Phone:** _____

Email Address: _____ **Gender:** M / F **Marital Status:** Single / Married / Other

Social Security #: _____ **Date of Birth:** _____

Student Status: Full Student / Part Student / Non-Student **Employed:** Y / N **Where:** _____

Ethnicity: Hispanic or Latina / Not Hispanic or Latino / Decline **Preferred Language:** English / Decline / Other: _____

Race: Asian / African American / American Indian or Alaskan Native / Other / Native Hawaii or Pacific Islander / White / Decline

Smoker: Everyday / Some Days / Former / Never

**** Referred By:** _____ Family / Friend / Co-Worker / Doctor/ Other Source

Emergency Contact Information

Name: (First MI Last) _____ **Primary Care Physician:** _____

Phone: _____ **Doctor's Phone:**_____

Relationship: Child / Parent / Spouse / Other: _____

Insurance / Financial Information

Who is responsible for payment? Self / Other - Name: _____ **Relationship:** _____

☐Insurance☐ Worker's Comp ☐ Self-Pay (Cash) ☐ Personal Injury / Auto ☐ Other (please explain): _____

Primary Insurance Name: _____ **Secondary Insurance Name:** _____

***** (Please supply insurance cards to office staff so that they can be copied)***

Consent to Treat, Authorization to Release & HIPPA

AUTHORIZATION: By signing below you authorized this office/provider to complete a consultation, examination, chiropractic care, diagnostic testing and /or therapeutic services on the above, in accordance with this state's statutes. By signing below, you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below, you consent to the taking of x-rays if there is a determined need.

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS: By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below, you furthered acknowledge understanding that your health and accident insurance information policies are an arraignment between you and your carrier, and that you may be required to pay some, or all of the fees charged to your account. By signing below, you hereby assign benefits to paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below, you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below, you have authorized this office to contact you for office related matters in the following manner: phone-work-home or mobile, e-mail and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also, in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013,this office is obliging to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below, you have acknowledged that you have been offered a copy of this document.
ACKNOWLEDGEMENT: By signing below you have acknowledged that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below, you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are a true and accurate to the best of your knowledge.

Signature of Patient: _____ ***Signature of Parent or Guardian:*** _____ ***Date:*** _____

(It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged)

COMPLAINT INFORMATION

Date: _____ **Patient No:** _____

History of Current Condition

Major Complaint: _____

Secondary Complaint: _____

When and How this began? _____

_____

_____

Intensity of Pain/Complaint: None (0) / Mild (1-2) / Mild-Mod (2-4) / Moderate (4-6) / Mod-Severe (6-8) / Severe (8-10)

Quality of pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore

How frequent is the complaint? Off & On / Constant

Does the complaint radiate? No / Yes (Describe) _____

Head - Base of Skull / Forehead / Temple L / R / Both Leg - Hip / Thigh-Knee / Calf / Toes L / R / B

Arm - Across Shoulder / Elbow / Hand-Fingers L / R / Both Other Area: _____

What makes it Better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

What makes it Worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

Which daily activities are being affected? (*Describe*) _____

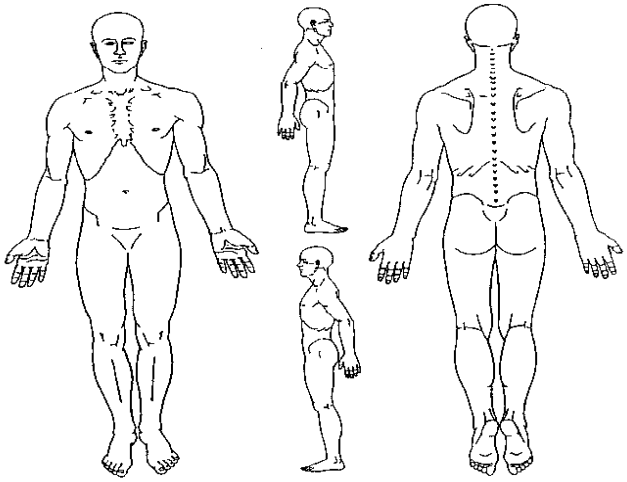
For this condition, have you:

Other Treatment? None / DC / MD / PT / Massage / Other: _____ Where: _____

Other Diagnostic Testing? X-rays / MRI / CT / Other: _____ Where: _____

Pain/Complaint Diagram

SYMPTOM DIAGRAM



S ___ Spasm

T ___ Tenderness

P___ Pain

N ___ Numbness

Patient Signature: _____ ***Physician's Initials:*** _____

Health History

Patient Name: (First MI Last) _____ **Patient No:** _____

Please check all conditions that apply.

Zone 1:
- ☐ Memory Loss
- ☐ Sleep Problems
- ☐ Skin Problems
- ☐ Hair Loss/Condition
- ☐ Menstrual Problems
- ☐ Thyroid/Energy Loss
- ☐ Adrenal Condition
- ☐ Depression
- ☐ ED/Fertility
- ☐ Anger Easily
- ☐ Unable to Concentrate
- ☐ Low Immunity

Zone 2:
- ☐ Sinus Drainage
- ☐ Throat Pain
- ☐ Kidney Condition
- ☐ Bladder Problems
- ☐ Constipation/Diarrhea
- ☐ Nasal Passages
- ☐ Lung Problems
- ☐ Cough
- ☐ Lymphedema
- ☐ Bloating

Zone 3:
- ☐ Eyes / Poor Eyesight
- ☐ Balance / Dizziness
- ☐ Poor Sleep
- ☐ Low Energy
- ☐ Unable to Relax
- ☐ Nervousness
- ☐ Ears / Hearing Loss
- ☐ Tingling in Extremities
- ☐ Allergies/Food Issues
- ☐ Indigestion
- ☐ Mood Swings
- ☐ Hormone Imbalances

Zone 4:
- ☐ Excessive Appetite
- ☐ Acid Reflux
- ☐ Liver Conditions
- ☐ Stomach Issues
- ☐ Intestinal Issues
- ☐ Indigestion
- ☐ Poor Taste
- ☐ Heartburn
- ☐ Gallbladder Conditions
- ☐ Pancreas/Diabetes
- ☐ Weight Gain
- ☐ Bowel Issues

Zone 5:
- ☐ Neck Pain
- ☐ Arms/Hand Pain
- ☐ Middle Back Pain
- ☐ Legs/Feet Pain
- ☐ Abdomen Pain
- ☐ Disc Problems
- ☐ Shoulder Pain
- ☐ Upper Back Pain
- ☐ Lower Back Pain
- ☐ Chest Pain
- ☐ Muscle Weakness
- ☐ Muscle/Joint Pain

Zone 6:
- ☐ Thyroid Conditions
- ☐ Blood Pressure Issues
- ☐ Heart Problems
- ☐ Headaches/Migraines
- ☐ Cold Hands
- ☐ Cold Feet
- ☐ Poor Circulation

Health History

Medications and Supplements:

Allergies to Medications: ☐NONE

Name	Reaction

Current Medications & Supplements: ☐NONE

Name	Dosage

Past Health History:

Surgeries: ☐NONE

Date	Describe

Date	Describe

Family Health History: ☐NONE

List major health problems of 1st degree relatives:

Problem	Relation (Parent, Sibling, Child)

Social and Occupational History:

Smoking: ☐Every Day ☐Some Days ☐ Former ☐Never

Habit	Type / Amount / Year Started
Smoking	
Tobacco	
Alcohol	
Caffeine	
Rec. Drugs	

Major Injuries / Traumas / Hospitalizations: ☐NONE