Chiropractic Partners

Phone: (919) 572-2312
Fax: (919) 572-2437

5007 South Park Drive, Suite 130
Durham, NC 27713

ACCIDENT HISTORY REPORT

Please complete this form as accurately as possible. Your answers will help us determine whether chiropractic can help you. If we do not sincerely believe your condition cannot respond satisfactorily, we will not accept the case. Thank you for your cooperation.

General Information/Past Medical History

Name: _____ Age: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: (H) _____ (W) _____ Social Security _____
Male / Female Martial Status: M S W D Spouse's Name: _____ # of Children: _____
Driver's License Number: _____ Your Occupation: _____
Employer: _____ Referred by: _____
Emergency Contact: _____ Phone #: _____ Relationship: _____
Responsible Party of Bill: _____

Please check the appropriate box if any of the following apply to you (past or present)

GENERAL	Severe	Mod	Mild
Allergy	☐	☐	☐
Dizziness	☐	☐	☐
Ear Problems	☐	☐	☐
Fatigue	☐	☐	☐
Colds/Sinus Infections	☐	☐	☐
Headaches	☐	☐	☐
Nervousness	☐	☐	☐
Nose Bleeds	☐	☐	☐
Numbness	☐	☐	☐
Sore Throat	☐	☐	☐
Sudden Weight Loss/Gain	☐	☐	☐
Tonsillitis	☐	☐	☐

GENITO-URINARY			
Frequent Urination	☐	☐	☐
Inability to Control Urine	☐	☐	☐
Kidney Infection or Stones	☐	☐	☐
Painful Urination	☐	☐	☐
Prostate Trouble	☐	☐	☐

CARDIO-VASCULAR			
High Blood Pressure	☐	☐	☐
Heart Condition	☐	☐	☐
Swelling of Ankles	☐	☐	☐

GASTROINTESTINAL	Severe	Mod	Mild
Constipation	☐	☐	☐
Diarrhea	☐	☐	☐
Gall Bladder Trouble	☐	☐	☐
Intestinal Trouble	☐	☐	☐
Nausea/Vomiting	☐	☐	☐
Stomach Problems	☐	☐	☐

RESPIRATORY			
Chest Pain	☐	☐	☐
Chronic Cough	☐	☐	☐
Difficulty Breathing	☐	☐	☐

MUSCLE & JOINT			
Ankle Pain	☐	☐	☐
Arm/Shoulder Pain	☐	☐	☐
Elbow Pain	☐	☐	☐
Foot Trouble/Pain	☐	☐	☐
Knee Pain	☐	☐	☐
Leg Pain	☐	☐	☐
Neck Pain	☐	☐	☐
Pain between Shoulders	☐	☐	☐
Lower Back Pain	☐	☐	☐
Rib Pain	☐	☐	☐
Swollen Joints	☐	☐	☐

DO YOU HAVE:	Yes	No
AIDS	☐	☐
Alcoholism	☐	☐
Anemia	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Heart Disease	☐	☐
Mental Disorders	☐	☐
Nervous Breakdown	☐	☐
Polio	☐	☐
Rheumatic Fever	☐	☐

FOR WOMEN ONLY		
Hot Flashes	☐	☐
Irregular Cycle	☐	☐
Lumps in Breast	☐	☐
Painful Menstruation	☐	☐

HABITS

Coffee/Tea _____ Cups/Day
Tobacco _____ Pack(s) / _____
Alcohol _____ Drinks / _____
Sleep _____ Hrs/Night

Accident History

Date of Accident: _____ Approx time: _____
Please describe the accident in your own words: _____
_____
_____
_____
Type of vehicle you were in? (Year/make/model) _____ / _____ / _____
Were you the driver or a passenger? _____ How were you positioned? (please give specific head and body orientation) _____
Were you wearing your seat belt? YES / NO Position of headrest (up, down, etc)? _____
Were you aware of the collision before impact or were you caught by surprise? _____
Was the vehicle stopped at the time of the impact? YES / NO If yes, was the driver's foot on the brake? _____
If no, what speed was the vehicle moving? _____ Was the vehicle accelerating, slowing down, or traveling at a steady speed? _____
_____
Year / Make / Model of the other vehicle: _____ / _____ / _____
Approx speed of other vehicle: _____ Were they accelerating, slowing down or traveling at a steady pace? _____ Do you have pictures from the scene? YES / NO
Please describe the road conditions: _____
Was your vehicle hit from the FRONT / RIGHT / LEFT / REAR Please describe any damage to the outside and/or inside of the vehicle: _____
_____
_____
Were the police called? YES / NO If yes, do you have a copy of the police report? YES / NO What city were the police from? _____ County: _____ State: _____ Was an ambulance called? YES / NO
Was there a ticket issued? YES / NO If yes, to whom? _____ For what? _____
_____
Any other important details you would like to include? _____
_____

Describe your injuries and symptoms: _____
_____
_____
Did you lose consciousness at any time? YES / NO If yes, please describe: _____
Does it trouble you to ride in a vehicle? YES / NO If yes, as a driver or passenger? _____
Do you remember the impact? YES / NO Have you missed work/school? YES / NO If yes, list dates: _____
Have you needed outside help? YES / NO If yes, describe kind of help needed: _____
Did any part of your body hit anything during the collision? (e.g. head on dash, chest on steering wheel, etc) If yes, describe
_____
_____
How did you leave the scene? _____ Where did you go after the accident? _____
Were you hospitalized? YES / NO If yes, how long? _____ Where? _____
Were you X-Rayed? YES / NO If yes ,which body part? _____ By whom? _____
Did you receive health care from anyone? YES / NO If yes, from whom? _____
Type of care received? _____ For how long? _____
Have you been previously injured in a similar manor? YES / NO If yes, please provide date (s) with descriptions: _____
_____

To the best of my knowledge, the preceding answers to the questions on this form are the complete truth regarding my health and accident history.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

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FUNCTIONAL INDEX SCALES: NECK

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the questions, marking ONE number on EACH scale that best describes how you feel.

1. Since the accident, on average, how would you rate your neck pain?

No pain										Worst possible pain
0	1	2	3	4	5	6	7	8	9	10

2. Since the accident, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference										Unable to do any activity
0	1	2	3	4	5	6	7	8	9	10

3. Since the accident, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference										Unable to do any activity
0	1	2	3	4	5	6	7	8	9	10

4. Since the accident, how anxious (tense, uptight, irritable, difficult in concentrating/relaxing) have you been feeling?

Not Anxious										Extremely anxious
0	1	2	3	4	5	6	7	8	9	10

5. Since the accident, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not depressed										Extremely depressed
0	1	2	3	4	5	6	7	8	9	10

6. Since the accident, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Unaffected										Extremely Affected
0	1	2	3	4	5	6	7	8	9	10

7. Since the accident, how much have you been able to control (reduce/help) your neck pain on your own?

Complete control										No control at all
0	1	2	3	4	5	6	7	8	9	10

_____ _____

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FUNCTIONAL INDEX SCALES: BACK

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the questions, marking ONE number on EACH scale that best describes how you feel.

8. Since the accident, how would you rate your back pain?

No pain										Worst possible pain
0	1	2	3	4	5	6	7	8	9	10

9. Since the accident, how much has your back pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference										Unable to do any activity
0	1	2	3	4	5	6	7	8	9	10

10. Since the accident, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference										Unable to do any activity
0	1	2	3	4	5	6	7	8	9	10

11. Since the accident, how anxious (tense, uptight, irritable, difficult in concentrating/relaxing) have you been feeling?

Not Anxious										Extremely anxious
0	1	2	3	4	5	6	7	8	9	10

12. Since the accident, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not depressed										Extremely depressed
0	1	2	3	4	5	6	7	8	9	10

13. Since the accident, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Unaffected										Extremely Affected
0	1	2	3	4	5	6	7	8	9	10

14. Since the accident, how much have you been able to control (reduce/help) your back pain on your own?

Complete control										No control at all
0	1	2	3	4	5	6	7	8	9	10

_____ _____

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ASSIGNMENT OF BENEFITS

To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

IN CONSIDERATION of the willingness of Chiropractic Partners to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to Chiropractic Partners any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on _____ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to Chiropractic Partners, from any disability benefits, medical payments benefits, liability benefits, health and accident benefits, workers' compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due or may become due to Chiropractic Partners for its services rendered.

I appoint Chiropractic Partners as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am a named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Chiropractic Partners.

I authorize Chiropractic Partners to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to Chiropractic Partners for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If Chiropractic Partners is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse Chiropractic Partners for its costs of recovery, including reasonable attorney's fees.

_____
Patient

_____
Date

_____
Witness

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CONSENT OF USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we have to use or disclose our health care information:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer your to them for diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent for (164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your Right to Limit Uses or Disclosure

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree to your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____ _____

Printed Name Authorized Provider Representative

_____ _____

Signature Date

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INFORMED CONSENT
TO CHIROPRACTIC ADJUSTMENTS AND CARE

To be completed by patient or patient's legal representative, if necessary, e.g., if patient is a minor or physically or legally incapacitated:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and diagnostic x-rays on me (Or on the patient named below, for whom I am legally responsible) by Dr. Arturo Presas and/or other licensed doctors of chiropractic who now or in the future treat me while employed by working with or associated with servicing as back up for the doctor of chiropractic named above, including those working at the clinic or office listed or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. 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 on facts then known, is in my best interests.

During your examination, the doctor may feel that x-rays will be needed in order to fully diagnose your condition and administer proper treatment. In order to perform x-rays on any patient, our office requires patient consent for such procedures to be performed.

Please Choose One:

_____ I understand that my doctor may need x-rays in order to diagnose my condition and I give permission of all needed diagnostic tests.

_____ I understand that my condition may require my doctor to take x-rays to further diagnosis my symptoms. I choose not to have any x-rays taken at this time and release my doctor of Chiropractic of all liabilities.

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

_____	_____	_____
Print Patient's Name	Signature (Patient or Guardian)	Date
_____	_____	_____
Witness (Print Name)	Signature	Date

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PERSONAL INJURY
INSURANCE INFORMATION

Please provide us with the following information related to your personal injury case. Thank you.

YOUR AUTO INSURANCE

Name of Insurance Company:

Policy Number: Policy Holder's Name:

Claim Number:

Adjuster Name: Phone Number:

Address:

THIRD PARTY (LIABILITY)

Name of Insurance Company:

Policy Number: Policy Holder's Name:

Claim Number:

Adjuster Name: Phone Number:

Address:

ATTORNEY INFORMATION (if applicable)

Attorney Name: Phone Number:

Address:

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AUTO ACCIDENT COVERAGE & PAYMENT OPTIONS

Please review the following payment options, and choose the ***one*** that best meets your needs:

Liability and Med Pay Combination:
Upon verification of benefits, we will file all insurance claims to both insurance sources. The Med Pay portion of your auto insurance policy will be filed weekly throughout care. *Please note: Filing to your Med Pay should not affect your coverage or rates, and is a benefit that you are entitled to receive.* The Liability Insurance Company (of the person responsible for the accident) will be filed upon your dismissal from care. Filing claims to both sources provides better assurance of coverage; however, you are responsible for any remaining balance, after insurance processing. Any/all overpayments will be refunded to you after all insurance processing has been completed. It is your responsibility to provide us with any/all Med Pay and third party payer (Liability) information. *You will be asked to pay for each visit, in full, if the information is not received by your third visit.* Initial: _____

Personal Health Insurance:
We will also file to your health insurance company (upon verification of benefits), if they do not have the right of subrogation (the right to request a refund if the liability company pays). Because this is a third part liability case, and we have a contract with your personal health insurance company, you will be required to pay your copay at the time services are rendered. After all insurance processing has been completed, you are responsible for any remaining balance, and any/all overpayments will be refunded to you. Initial: _____

Attorney Representation:
If liability insurance is the only form of coverage, or if we consider your case to have potential coverage problems, and you will have to retain an attorney, we would provide you a list of local attorneys. If represented by an attorney, we will hold a signed lien on payments up to our full fees, and will also file to Med Pay, if available. If our fees are reduced in the settlement, for any reason, you are responsible for the remaining balance, up to our full fees.

Initial: _____

Please note:
In order for us to file on your behalf, you will need to sign a Lien and an Assignment of Benefits, which will be remitted to the insurance companies, and attorney (if applicable), which confirms that payment will be made in full, directly to our office. If any payments are mailed directly to you, they are to be forwarded to our office upon receipt. Receipts for services or account statements will not be provided to a patient until the account balance has been paid in full, either by the insurance company or the patient. If you choose to suspend or terminate your care, any fees for services rendered become payable in full. If settlement has not been made within 6 months after your dismissal from care, a 5% interest rate will be charged to your account balance, accruable every month until balance is paid in full, beginning 30 after your dismissal from care.

Please Note:
Receipts of services or account statements will only be provided to a patient upon the payment of all services either by the insurance company or patient.