Motor Vehicle Accident Intake Form

ABOUT YOU

Name:			Date:	
Address:		City:	Sate	Zip Code
Date of Birth:	Age	Gender	Marital Status	Dominant hand: [ ] RIGHT [ ] LEFT
Emergency Contact:		Relation:		Emergency Phone Number:
Home Phone:		Mobile:		Email:

EMPLOYER INFORMATION

Employer Name:		Supervisor Name:	
Employer Address:	City:	State:	Zip Code
Work Phone:		Occupation:	

ACCIDENT INFORMATION

Date of Accident:	Time of Accident:	Where were you located in the vehicle: [ ] Driver [ ] Passenger [ ] Back Seat
Please describe the accident in your own words:		
Was a police report filed?: [ ] YES [ ] NO Police on scene?: [ ] YES [ ] NO	Number of people in car:	Names of people in car:
Did you go to the hospital?: [ ] YES [ ] NO Name of hospital:	How did you get to the hospital?: [ ] AMBULANCE [ ] PRIVATE	Date of hospital visit: Doctor's name:

Diagnosis:	X-rays taken?: [ ] YES [ ] NO Type of treatment received:
Have you been treated by any other doctor for this accident?: [ ] YES [ ] NO	Since the injury, are your symptoms: [ ] IMPROVING [ ] GETTING WORSE
Have you lost time from work?: [ ] YES [ ] NO	Date you left work: Date you returned:
Have you been in an accident in the past?: [ ] YES [ ] NO	If yes, please describe:
Do you have any previous illnesses which relate to this case?:	If yes, please describe:
Do you have any activity restrictions as a result of this injury?:	If yes, please describe:

ACCIDENT SITE	IMPACT
Road/Street Name:	Did your car impact another vehicle?: [ ] YES [ ] NO
City/State:	Did your car impact a structure?: [ ] YES [ ] NO
Nearest Intersection:	Did any part of your body strike anything in the vehicle?:
Driving Conditions: [ ] WET [ ] DRY [ ] ICY/SNOW	Were you knocked unconscious?: [ ] YES [ ] NO
Were you struck from: [ ] BEHIND [ ] FRONT [ ] LEFT SIDE [ ] RIGHT SIDE	At the time of impact were you: [ ] looking straight ahead [ ] looking to the right [ ] looking to the left [ ] looking down/up
Speed you/other care was traveling?	Was impact from: [ ] FRONT [ ] BEHIND [ ] LEFT [ ] RIGHT
Did you apply brakes? [ ] YES [ ] NO	Was your foot on the brake?: [ ] YES [ ] NO LEFT / RIGHT FOOT?
VEHICLE	Were both hands on the steering wheel?: [ ] YES [ ] NO
Make and Model of vehicle:	If no, which hand was on the wheel?: [ ] RIGHT [ ] LEFT
Were you wearing a seatbelt?: [ ] YES [ ] NO	Were you: [ ] Surprised by impact [ ] Braced for impact
Was vehicle equipped with airbags?: [ ] YES [ ] NO	Did airbags inflate properly?: [ ] YES [ ] NO
Did your seat have a head rest?: [ ] YES [ ] NO	What was the position of the headrest?: [ ] LOW [ ] MID [ ] HIGH

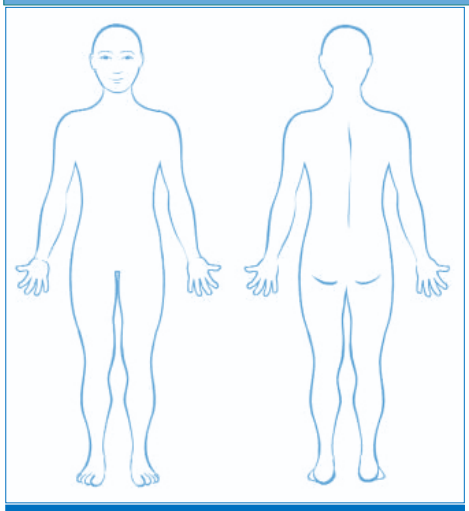
INSURANCE INFORMATION

Auto Insurance Company:	Billing Address:
Adjustor Name:	Claim Number:
Policy Number:	Phone Number:

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

[ ] Headache
[ ] Neck pain
[ ] Neck stiffness
[ ] Sleeping problems
[ ] Back pain
[ ] Back stiffness
[ ] Nervousness
[ ] Tension
[ ] Irritability
[ ] Chest pain
[ ] Diarrhea
[ ] Constipation
[ ] Fever
[ ] Arm/shoulder pain
[ ] 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
[ ] Jaw problems
[ ] Leg pain
[ ] Light bothers eyes
[ ] Loss of memory
[ ] Ears ring
[ ] Face is flushed
[ ] Loss of balance
[ ] Fainting
[ ] Loss of smell
[ ] Loss of taste
[ ] Upset stomach
[ ] Buzzing in ears
[ ] Blurred vision
[ ] **OTHER:**

Mark any areas using the following codes for type of pain: N= Numbness P= Pain A= Ache T= Tingling S= Stiffness/Soreness



Please rate your pain on a scale of **1** (little to no pain) to **10** (severe pain):

1 2 3 4 5 6 7 8 9 10

COMMENTS:

_____

_____

_____

Is this condition getting progressively worse?: [ ] YES [ ] NO

How often do you have this pain?: _____

Is it constant or does it come and go?: _____

Does it interfere with: [ ] WORK [ ] SLEEP [ ] DAILY ROUTINE [ ] RECREATION

Movements that are painful: [ ] SITTING [ ] STANDING [ ] BENDING [ ] LYING DOWN

What makes it feel better or worse?: _____

_____

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

TERMS OF ACCEPTANCE

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. Our 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 nerve function and interference of the transmission of 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 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:
Witness signature:	Date:

FOR THE DOCTOR

NOTES:

_____

_____

_____

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AUTHORIZATION FOR CARE

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.

Signature:	Date:
Signature of guardian or spouse authorizing care:	Date:

HIPPA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you.

However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

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

If YES, please name the members allowed:	
This consent was signed by:	
Patient Signature:	Date:
Witness Signature:	Date: