Swickard Chiropractic Clinic of Shawnee, P.A.
17202 Midland Drive, Shawnee, KS 66217

Mark A. Swickard, DC
Bret Lickteig, DC

# Auto Accident Intake Form

First Name: ____________________________ M.I. ______ Last Name: ________________________________

Address: ______________________________City ________________ State __________ Zip Code ___________

H. Phone __________________________W. Phone________________ Cell Phone ________________________

Email Address: _______________________________________________________

Sex M F Marital Status M S D W Date of Birth____________Age______Social Security #___________________

If married, Spouse's Name:_______________________________________________# of Children_____________________

Occupation_______________________________________________Employer___________________________________

Primary Care Physician Name:_________________________________________________________________
Address:________________________________________________________ Phone _____________________________
I give you permission to share a brief summary of my case and diagnosis with my primary care physician.
□ Yes □ No Initial: ________

Have you ever received Chiropractic Care? Yes No If yes, when? ________________________
Name of most recent Chiropractor: ________________________________________________________________

Referred by: ____________________________________________________________

**1. Reasons for seeking chiropractic care:**

Primary reason:
_____________________________________________________________________________________________

Secondary reason:
_____________________________________________________________________________________________

**2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

**3. Past Health History:**

**A. Please indicate if you have a history of any of the following:**
□ Anticoagulant use □ Heart problems/high blood pressure/chest pain □ Bleeding problems
□ Lung problems/shortness of breath □ Cancer □ Diabetes □ Psychiatric disorders
□ Bipolar disorder □ Major depression □ Schizophrenia □ Stroke/TIA's □ Other __________
□ None of the above

**B. Previous Injury or Trauma:**
_____________________________________________________________________________________________

**Have you ever broken any bones? Which?**
_____________________________________________________________________________________________

**C. Allergies:** ___________________________________________________________________________

Name/Initial: ____________________________________ Date: _____________________________

# Auto Accident Intake Form

**D. Surgeries:**

Date | Type of Surgery

____________________
____________________
____________________
____________________

**E. Females/ Pregnancies and outcomes:**

Pregnancies/Date of Delivery | Outcome

____________________
____________________
____________________
____________________

**F. Prior Imaging (ie., X-rays, MRI, CT, etc):**

What Images were performed? | Reason they were done:

____________________
____________________
____________________
____________________

**4. Family Health History:**

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches
□ Cardiac disease □ Neurological diseases □ Diabetes
□ Psychiatric disease □ Adopted/Unknown □ Cardiac disease below age 40
□ Other ____________________ □ None of the above

Deaths in immediate family: ____________________
Cause of parents or siblings death | Age at death

____________________
____________________
____________________
____________________

**Social and Occupational History:**

**A. Job description:**
____________________

**B. Work schedule:**
____________________

**C. Recreational activities:**
____________________

**D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):**

____________________

Name/Initial: ____________________ Date: ____________________

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**Review of Systems**

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other ____________ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other ___________ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell □ Strokes/TIAs □ Other _______________ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other ________________ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other ______________________ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _________ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _______________ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other __________ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other ______________________ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other ____________ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here?
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Name/Initial: ____________________________________ Date: _____________________________

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# Auto Accident Intake Form

***Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.***

Symptom 1 ________________________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ______________________________________________________________
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _________________________________________________________
- What movements/activities make the symptom worse?
  - Please describe:______________________________________________________________________
- What makes the symptom better?
  - Please describe:______________________________________________________________________
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): ______________________________________________________________
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? ______________________________________________
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Doctor's Notes:

Symptom 2 ________________________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ______________________________________________________________
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _________________________________________________________
- What movements/activities make the symptom worse?
  - Please describe:______________________________________________________________________
- What makes the symptom better?
  - Please describe:______________________________________________________________________
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): ______________________________________________________________
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? ______________________________________________
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Doctor's Notes:

Name/Initial: ____________________________________ Date: ____________________________

# Auto Accident Intake Form

Symptom 3 ________________________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ________________________________________
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? ________________________________________
- What movements/activities make the symptom worse?
  - Please describe:________________________________________
- What makes the symptom better?
  - Please describe:________________________________________
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): ________________________________________
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? ________________________________________
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Doctor's Notes:

Symptom 4 ________________________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ________________________________________
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? ________________________________________
- What movements/activities make the symptom worse?
  - Please describe:________________________________________
- What makes the symptom better?
  - Please describe:________________________________________
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): ________________________________________
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? ________________________________________
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Doctor's Notes:

Name/Initial: ________________________________________ Date: ______________________________

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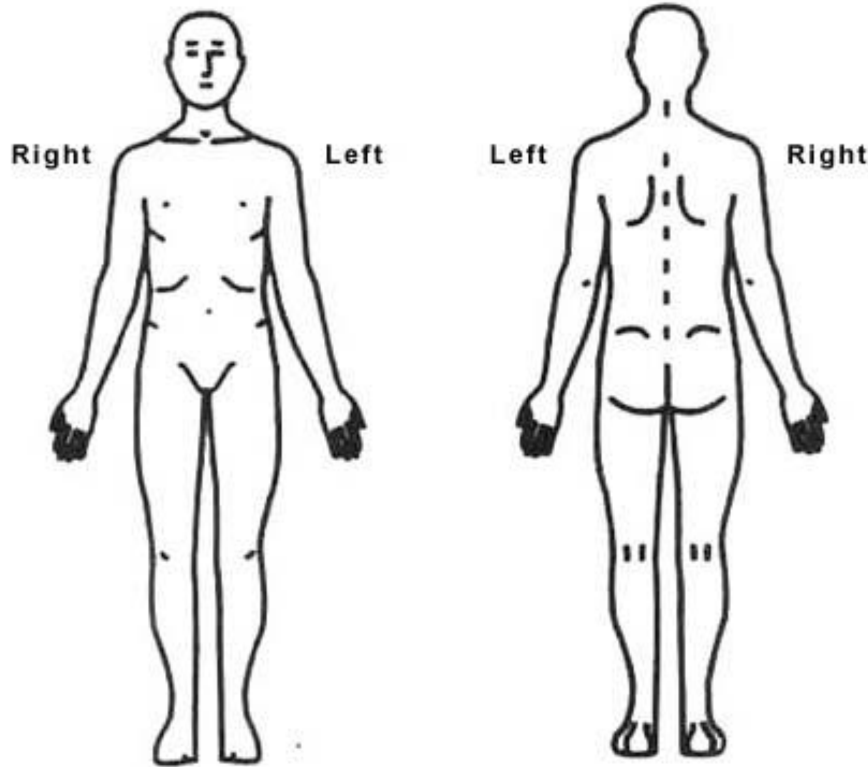
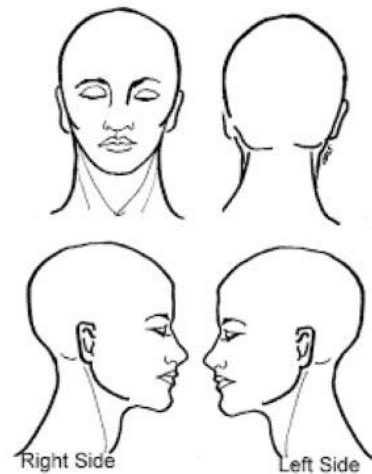
Please indicate sites of **pain** with an "X". (×××)
Does the **pain radiate (travel)**? If so, mark with an "arrow". (→→→)




## Do you have headaches?

□ Yes □ No, skip to next page.

**If yes, please answer the following:**




a. **Mark where you get your headache(s) with an "X"**
b. **On a scale from 0-10, with 10 being the worst, indicate the intensity of your headache:** 1 2 3 4 5 6 7 8 9 10
c. **What describes your headaches?** (circle all that apply)
Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other: ________________________
d. **How often do they occur?**
________ X/week ________ X/month _______ Sporadic
e. **Are your headaches worse at certain times of the day or night?**
Morning Afternoon Evening Night Unaffected time of day
f. **When did your headaches begin?** ________________________
g. **What makes your headaches worse?** ______________________
h. **What makes your headaches better?** ______________________

Name/Initial: ____________________________________ Date: ____________________________

# Auto Accident Intake Form

## Auto Accident Mechanism of Injury Form

Date of Collision: _____________________________ Hour of Accident: ___________________ AM / PM

Where did the accident occur? _________________________________________ What State?__________________

Please describe how the collision happened: ___________________________________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

1. What was your position in the car? (Circle) **Driver** / **Front Passenger** / **Left Rear** / **Right Rear**
    a. If "Driver", were your hands on the steering wheel? **Both** / **Left** / **Right**
2. Did the airbags deploy? **Yes** / **No**
3. Did you strike another vehicle? **Yes** / **No**
    a. Did another vehicle strike your vehicle? **Yes** / **No**
4. Angle of Impact: **Front** / **Back** / **Left** / **Right** / **Other**: _____________________________________________
5. If Second Collision – Angle of 2nd impact: **Front** / **Back** / **Left** / **Right** / **Other**: ________________________
6. In relation to the back of your head, was your headrest set: **Low** / **Middle** / **High**
7. Were you surprised by the impact? **Yes** / **No**
    a. If "NO", how did you brace? **With Hands** / **With Feet**
8. Where was your head facing at the time of impact? **Straight Ahead** / **Left** / **Right** / **Behind**
9. Were you leaning forward at the time of impact? **Yes** / **No**
10. What type and year of vehicle were you in? _______________________________________________________
11. What was the approximate speed of your vehicle when the accident occurred? _____________ mph
12. What type and year of vehicle struck yours?_________________________________________________________
13. What was the approximate speed of the other vehicle when the accident occurred? ________ mph
14. Were you wearing a seatbelt? **Yes** / **No**
    a. What type: **Lap Belt** / **Shoulder Belt** / **Both**
15. Did you feel pain immediately after the accident? **Yes / No**
16. Were you rendered unconscious as a result of the accident? **Yes / No**
17. Did you strike anything in the vehicle at the time of impact? **Yes** / **No** If "YES", specify what part of your body struck what: (i.e. head, chest, chin, shoulder, knee, etc.)
    a. Steering Wheel
    b. Dashboard
    c. Left Side Door
    d. Left Window
    e. Other
    f. Windshield
    g. Roof
    h. Right Side Door
    i. Right Window
18. Did your seat break or bend? **Yes** / **No**
19. Immediately following the accident, how did you feel? (Circle all that apply) **Dizzy** / **Dazed** / **Weak** / **Upset** / **Disoriented** / **Nervous** / **Nauseous** / **Other**: ___________________________________________

Name/Initial: ______________________________________ Date: ______________________________

# Auto Accident Intake Form

## Police and Ambulance:

1. Was the accident reported to the police? **Yes** / **No**
2. Were traffic citations issued? **Yes** / **No**
    a. If "YES", to whom? ________________________________
3. Did you go to the hospital? **Yes** / **No**
    a. If "YES", when? ____________________________________
    b. If "YES", how did you get there? **Ambulance** / **Police Car** / **Private Transportation**
4. Were you admitted? **Yes** / **No**
    a. If "YES", how long? ________________________________________
5. Name of Hospital? ____________________________________ Attended by Dr. ____________________
6. What treatment given? (Circle all that apply) **None** / **X-rays** / **Pain Medication** / **Stitches /** **Muscle Relaxants** / **Bandaged** / **Cervical Collar** / **Physical Therapy** / **Instructed Regarding Concussion** / **Instructed Regarding Sprains & Strains** / **Instructed to Call an Orthopedist** / **Instructed to Call a Private Physician** / **Referred to This Office** / **Other**: ____________________
7. What other doctor have you seen as a result of this injury? _____________________________________
8. Do you have difficulty in excessive: **Standing** / **Walking** / **Riding** / **Bending** / **Twisting**
9. Do you have difficulty in excessive lifting: **Light** / **Moderate** / **Heavy** / **Repetitive**
10. Symptoms other than above: ______________________________________________________________

# Auto Accident Intake Form

## HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

**Use and Disclosures of Protected Health Information:**
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

____________________________________ ________________________
Signature of Patient of Representative Date

____________________________________
Printed Name

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# Auto Accident Intake Form

**AUTO INSURANCE:**

INSURANCE COMPANY: ______________________________ PHONE: ____________

INSURANCE ADDRESS: ______________________CITY: __________ STATE: ___ ZIP: _____

ADJUSTER NAME: ____________________________ ADJUSTER PHONE: ____________

POLICY NUMBER: ______________________ CLAIM NUMBER: ____________________

Do you have an attorney on this claim? **Yes** / **No**

**HEALTH INSURANCE:**

INSURANCE COMPANY:____________________________________________

INSURED'S NAME: ____________________RELATIONSHIP TO INSURED:______________

INSURED'S BIRTHDATE:_____________ PHONE NUMBER:_________________________

ADDRESS:_________________________CITY:___________ STATE:_____ ZIP:________

EMPLOYER NAME: ____________________________________________

**RELEASE OF INFORMATION:**

I ______________________________ give permission to the staff at Swickard Chiropractic Clinic of Shawnee, P.A. to share any information related to my care, account and services to the following people:

NAME: (LAST, FIRST, MI): ____________________________________
RELATIONSHIP: ____________________________________
ADDRESS______________________CITY:_______________ STATE:______ ZIP: _______
PHONE: ____________________________________

NAME: (LAST, FIRST, MI): ____________________________________
RELATIONSHIP: ____________________________________
ADDRESS______________________CITY:_______________ STATE:______ ZIP: _______
PHONE: ____________________________________

NAME: (LAST, FIRST, MI): ____________________________________
RELATIONSHIP: ____________________________________
ADDRESS______________________CITY:_______________ STATE:______ ZIP: _______
PHONE: ____________________________________

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Swickard Chiropractic Clinic of Shawnee, P.A. for services performed.

Patient or Guardian Signature ________________________ Date___________

Name/Initial: ________________________ Date: ____________________

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# Auto Accident Intake Form

# Electronic Health Records Intake Form

*This form complies with CMS EHR incentive program requirements*

**First Name:** ___________________________________ **Last Name:** ____________________________________
**Email address:** ________________________________@_________________________
**Preferred method of communication for patient reminders** (Circle one): Email / Phone / Mail
By providing my e-mail address, I understand that authorized personnel from Swickard Chiropractic may communicate with me regarding scheduling, treatment, receipts, statements, appointment reminders, health education, and promotional information. If you do not consent to e-mail communication, please initial here. ________

**DOB:** __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** __________________

**Smoking Status (Circle one):** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

**Smoking Start Date (Optional):** __________________

**Race (Circle one):** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer
**Ethnicity (Circle one):** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

**Are you currently taking any medications?** *(Include regularly used over the counter medications)*

| Medication | Dosage and Frequency (i.e. 5mg once a day, etc.) | Reason for Taking |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Do you have any medication allergies?**

| Medication | Reaction | Onset Date | Additional Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*
Patient Signature: _______________________________________________ Date: ________________

***For office use only***

Height: _________ Weight:____________ Blood Pressure:______ /______

Name/Initial: ______________________________________ Date: ______________________________