

PATIENT INFORMATION FORM - AUTO

Name: _____ Today's Date: ___/___/___

S.S.N.: _____ - _____ - _____ Gender: F M Age: _____ Date of Birth: ___/___/___

Marital Status: Married Divorced Widowed Single Number of Children: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: (_____) _____ Cell #: (_____) _____ Work #: (_____) _____

E-mail Address: (Please Print Clearly) _____

** We would appreciate getting an email address on our effort to go green. Your email address will only be used by our clinic for appointment reminders along with massage and chiropractic specials.

Employer: _____ Type of work: _____

Work Address: _____

City: _____ State: _____ Zip: _____

Student at: _____ Full-Time Part-Time

Spouse/Significant other: _____ Spouse's Date of Birth: ___/___/___

Address: _____ Phone #: (_____) _____

**This information is for promotional purposes only. We send out birthday specials along with other promotions going on in the clinic.

Emergency Contact: _____ Phone #: (_____) _____

How did you hear about our office:

**Please be specific in how you heard about our clinic.

Internet: _____

Phone Book: _____

Wellness Class: _____

Mailer/Email: _____

Family/Friend Referral: _____

Health Insurance Provider: _____

Location: _____

Other: _____

Is today's visit related to:

Work Car Accident Sports Injury Fall Home Injury Chronic Discomfort

Other Please explain: _____

If job related, have you made a report of your accident to your employer? Yes No

When did the pain or condition start: _____

Has the condition: Got Worse Stayed Constant Comes and Goes

Does the condition interfere with: Sleep Work Daily Routine Other Activities

Please explain: _____

Has this condition occurred before: Yes No

Please explain: _____

Prior Treatment for this condition: Yes No

Doctor Name: _____ Phone: (_____) _____

Treatment: _____

Results: _____

Describe the purpose of today's visit: _____

What makes the condition better and worse: _____

Do you wear: Heel lifts Sole lifts Inner soles Arch supports

Do you smoke: Yes No If yes how many per day: _____

Do you drink Alcohol: Yes No If yes how much per week: _____

Do you drink caffeine: Yes No If yes how much per day: _____

Do you exercise regularly: Yes No If yes how often per week: _____

Please check each of the conditions or concerns that you currently have (C) or have had in the past (P).

Each area of concern relates to an area of the spine and nerve function.

Cervical

| C | P | Condition |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches/Migraines |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | Head Colds |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Stiff Neck |
| <input type="checkbox"/> | <input type="checkbox"/> | Insomnia |
| <input type="checkbox"/> | <input type="checkbox"/> | Arm Pain |

Thoracic

| C | P | Condition |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand/Finger Numbness |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Conditions |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid conditions |
| <input type="checkbox"/> | <input type="checkbox"/> | Bronchitis/Pneumonia |
| <input type="checkbox"/> | <input type="checkbox"/> | Mid-back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers/Gastritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Gallbladder Issues |

Lumbar/ Sacral

| C | P | Condition |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation/Colitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritable Bowel |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | Menstrual Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Low-back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain/Numbness in Legs |
| <input type="checkbox"/> | <input type="checkbox"/> | Reproductive Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Spinal Scoliosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor Circulation |

Other Conditions/Concerns

| C | P | Condition | C | P | Condition | C | P | Condition |
|--------------------------|--------------------------|---------------|--------------------------|--------------------------|------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Shingles | <input type="checkbox"/> | <input type="checkbox"/> | Vascular/Joint Implants |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Hernia |
| <input type="checkbox"/> | <input type="checkbox"/> | ADD/ADHD | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack/Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer/Tumors | <input type="checkbox"/> | <input type="checkbox"/> | Hearing Problems | <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery/Pacemaker |

For Women Only:

Are you pregnant: Yes No

Are you nursing: Yes No

Painful Cycles: Yes No

Are you taking birth control: Yes No

Irregular Cycles: Yes No

Breast Implants: Yes No

Current Medications:

Cholesterol: Yes No

Tranquilizers: Yes No

Blood Pressure: Yes No

Pain Killers: Yes No

Stimulants: Yes No

Muscle Relaxers: Yes No

Blood Thinners: Yes No

Insulin: Yes No

Supplements / Vitamins: _____

Have you seen a Chiropractor before: Yes No Has anyone in your family: Yes No

Doctor Name: _____

Phone: (____) _____

Reason for visit: _____

Date Seen Last: ____/____/____

Goals for my Care: Relief Care Corrective Care Comprehensive Care

I want the Doctor to determine the type of appropriate care for my condition

Did you know: Doctors of Chiropractic work with the nervous system? Yes No

The nervous system controls all bodily functions and systems? Yes No

Chiropractic is the largest natural healing profession in the world? Yes No

For the purposes of the Consent Form, "Office" shall refer to: Advanced Chiropractic Back and Neck Pain Center.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

This is a shortened version of the HIPPA compliance. If you'd like to see our 4 page, detailed privacy notice, it is available upon request at the front desk to review and sign.

The information which I have provided is true and complete to the best of my knowledge.

Patient Name (please print): _____

Signature: _____

Date: ____/____/____

AUTOMOBILE ACCIDENT INFORMATION

ACCIDENT DETAILS:

Date of Accident: ____/____/____ Time of Day: ____ AM PM Location of Accident: _____

City or town and State in which accident took place: _____

Were you a Driver Passenger Pedestrian

Were you struck from Behind Right Side Left Side Front

Were you looking straight ahead, to the left, or to the right? Straight Ahead To the Left To the Right

Was your vehicle stopped to make a turn stopped for a traffic signal parked moving at the time of impact

Other: _____

Did your body strike anything in the car? YES NO Describe in detail: _____

Were you wearing a seat belt? YES NO

Describe in detail how the accident occurred: _____

Were you rendered unconscious as a result of the collision? YES NO

Were you taken to the hospital after the accident? YES NO By ambulance or private car? _____

Were you taken to the hospital *immediately* after the accident? YES NO

If not, how much time had elapsed before you went to the hospital? _____

Which hospital were you taken to? _____

Have you been x-rayed since the accident? YES NO

If so, where? _____

Have you lost any days of work as a result of the accident? YES NO

If so, how many days have you lost? _____

Have you ever been in a previous auto accident? Describe all instances, giving approximate dates of the accidents, as well as the injuries sustained.

Date

Injuries sustained

____/____/____

____/____/____

____/____/____

INFORMATION ABOUT THE PARTIES TO THE ACCIDENT:

Did a police officer write up a police report on the accident? YES NO

If yes, what police department wrote up the report? _____

Do you have a copy of the police report? YES NO (if yes, please provide our office with a copy of this report)

Was a ticket or citation issued by a police officer as a result of the accident? YES NO

Who received the ticket or citation? _____

Do you have any "courtesy slips" or other information concerning the other parties involved in the accident? YES NO
(if yes, please provide our office with a copy of this information)

Did the accident involve a *hit-and-run* driver? YES NO

Are you licensed to drive? YES NO (please provide our office with a copy of your license)

Is the car which you normally drive properly registered? YES NO (please provide our office with a copy of the registration)

Other: _____

Were you in your own vehicle or someone else's at the time of the accident? Check one.

my own vehicle my spouse's my parent's a friend's other

If you were in someone else's vehicle, answer the following:

Name of Owner: _____

Address of Owner: _____

Was there any property damage to either of the vehicles as a result of the accident?

both vehicles the other person's vehicle the vehicle I was in neither vehicle was damaged

Your Auto Insurance Company (at the time of accident): _____

Address: _____ City, State, Zip: _____

Phone: (_____) _____ Fax: (_____) _____

Have you been contacted by an adjuster from the other party's insurance company regarding this claim? YES NO

Name of Adjuster: _____ Company: _____

Address: _____ City, State, Zip: _____

Phone: (_____) _____ Fax: (_____) _____

Check all that apply: I have settled my personal injury claim with this company I have settled the property damage claim I have signed an agreement which will pay my medical expenses for a period of time (explain) _____

I have not signed any agreement, nor settled any portion of my claim.

Are you currently represented by an attorney? YES NO If NO, do you wish to retain an attorney YES NO

Name of Attorney: _____ Phone: (_____) _____