Personal Injury / Accident
Medical History Intake Form

Release Chiropractic and Wellness Center

Please provide your Driver's License to our staff for your file.

ABOUT YOU

Full Name: _____ Gender: ☐M ☐F Age:_____ Birth Date: _____/_____/_____

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

Social Security#: _____-_____-_____ Driver's License #: _____ Home Phone: (____) _____

Spouse's Name: _____ Referred by: _____ Cell Phone: (____) _____

Employer: _____ Occupation: _____ Work Phone: (____) _____

Employer Address: _____ City: _____ State:_____ Zip: _____

INSURANCE/ATTORNEY INFORMATION

Insurance Company of the Person at Fault: _____ Name of Agent: _____

Insurance Company Address: _____ City: _____ State: _____ Zip: _____

Insurance Company Phone #: _____ Agent's Phone #: _____

Claim Number: _____ Have you retained an attorney? ☐Yes ☐No

Your Attorney's Name:_____ Your Attorney's Phone: _____

Your Attorney's Address: _____ City: _____ State: _____ Zip: _____

ACCIDENT INFORMATION

Date of Accident: _____/_____/_____ Time of Accident: _____ ☐a.m. ☐p.m.

Your Vehicle: Year _____ Make _____ Model _____ Your Speed _____

Other Vehicle: Year _____ Make _____ Model _____ Other Vehicle Speed _____

Accident Type: ☐ Rear ended ☐ Head-on ☐ Broad-sided Damage to Your Vehicle: $_____ Other Vehicle Damage: $ _____

Describe the Accident:

_____

_____

_____

_____

ACCIDENT SPECIFICS (Mark each that applies to the accident):

Job or work related injury	□ Yes	□ No
Were you the	□ Driver	□ Passenger
If the passenger, were you	□ Front seat	□ Back seat
Were you wearing your seatbelt?	□ Yes	□ No
Impending collision, were you	□ Aware	□ Unaware
	□ Braced	□ Not braced
Did your head…	□ Strike object □ Break glass	□ Not strike object
Did you experience…	□ Shock □ Flash of light seen upon impact	□ Loss of consciousness
Did the airbag deploy?	□ Yes	□ No

IMMEDIATELY FOLLOWING THE ACCIDENT:

- □ Ambulance / Paramedics were called
- □ I was treated at scene
- □ Transported to hospital by ambulance
- □ I went to Hospital on my own
- □ I was diagnosed at the Hospital
- □ I was treated at the Hospital
- □ Medication was prescribed
- □ Follow-up was recommended

OTHER DOCTORS SEEN:

- □ Orthopedist
- □ Psychiatrist
- □ Massage Therapist
- □ Neurologist
- □ Physical Therapist
- □ Chiropractor
- □ Other

THE WEATHER WAS:

- □ Dry
- □ Sunny
- □ Rainy
- □ Snowy
- □ Cloudy
- □ Foggy

THE ROAD WAS:

- □ Dry
- □ Wet
- □ Icy
- □ Snowy

TIME OF DAY:

- □ Dawn
- □ Day
- □ Dusk
- □ Night

State your Emotions and Physical State i*mmediately following* the accident: _____

_____

_____

State your Emotions & Physical State *after the first few days*: _____

_____

_____

_____

SYMPTOMATOLOGY (Pain Characteristics for Major Area of Complaint):

The pain started _____

The pain is made better by _____

and worse by _____

The pain has the following qualities: _____

☐ There is ☐ There is not radiation into _____

☐ There is ☐ There is not referred pain into

_____

☐ There is ☐ There is not parasthesia (tingling/numbness) into:_____ _____

The pain is located _____

The pain is (as far as timing is concerned: i.e. comes & goes, constant, etc.)_____ _____ ___

DAILY ACTIVITIES

How many days out of an average week do you have pain? _____

How much time out of an average day are you in pain? _____

What are the worst times of day for the pain? _____

What are the best times of day for the pain? _____

How do the following activities affect your pain?

	No Change	Relieves	Increased	Duration
Sitting	☐	☐	☐	_____
Walking	☐	☐	☐	_____
Standing	☐	☐	☐	_____
Lying Down	☐	☐	☐	_____
Looking up	☐	☐	☐	_____
Looking Down	☐	☐	☐	_____
Lifting	☐	☐	☐	_____

PAIN RATING

On a scale of 1- 10, rate your pain

None 0 1 2 3 4 5 6 7 8 9 10 Severe

Describe the overall severity of the pain

- ☐ Mild Nuisance
- ☐ Mild to moderate but can live with it
- ☐ Moderate, having trouble coping with it
- ☐ Severe, it is ruining my quality of life

Progression

How is your pain compared to when it first appeared?

- ☐ Much improved
- ☐ Somewhat improved
- ☐ No change
- ☐ Somewhat worse
- ☐ Much worse

What do you do to relieve the pain? _____

_____

_____

_____

What are some recreational activities that you participated in before this current problem and which ones cannot be performed now to the same extent as before? _____

_____

_____

List your hobbies and exercise activities: _____

_____

Please mark each that applies to your Daily Activities:

- ☐ Has difficulty climbing stairs.
- ☐ Stays at home most of the time due to the problem.
- ☐ Changes position frequently to try and get comfortable.
- ☐ Walks more slowly than usual because of the problem.
- ☐ Does not do jobs around the house because of the problem.
- ☐ Has to use handrails to get up stairs, etc.
- ☐ Has to lie down and rest frequently due to the problem.
- ☐ Has to hold onto something to sit or stand from a chair.
- ☐ Has to get other people to do things for you.
- ☐ Has difficulty getting dressed due to the problem.
- ☐ Can only stand for short periods due to the problem.
- ☐ Has difficulty bending or kneeling due to the problem.
- ☐ Has difficulty turning over in bed due to the problem.
- ☐ Has a loss of appetite due to the problem.
- ☐ Can only walk short distances because of the problem.
- ☐ Has difficulty sleeping because of the problem.
- ☐ Has to get dressed with someone's help.
- ☐ Has to sit most of the day because of the problem.
- ☐ Is more irritable because of the problem.
- ☐ Stays in bed most of the day because of the problem.

How often do you have to stop activities and sit or lie down to control your symptoms?

- ☐ Several times a day
- ☐ Occasionally
- ☐ Approximately once per day
- ☐ Never
- ☐ All day

SOCIAL HISTORY

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Children How many? _____

- ☐ Smoker
- ☐ Non-smoker
- ☐ Drinks alcohol
- ☐ Do not drink alcohol
- ☐ Take recreational drugs
- ☐ Do not take recreational drugs

OCCUPATIONAL HISTORY

Your Employer _____

Job Title _____

Are your Job Duties physically demanding for you? ☐ Yes ☐ No

Have you had any disability time? ☐ Yes ☐ No

If you are currently working, which are you performing?

- ☐ Regular Duties
- ☐ Limited – Light Duties

What is your current job satisfaction:

- ☐ Very Satisfied
- ☐ Satisfied
- ☐ Dissatisfied
- ☐ Very Dissatisfied

Your highest level of education attained?

_____

MEDICAL HISTORY

List the Physicians and other practitioners your have seen for this problem: List the Medications you are currently taking:

_____

_____

_____

_____

List the treatments you have had for your problem

- ☐ Hot packs / Ultrasound
- ☐ Massage
- ☐ Electrical Stimulation
- ☐ TENS Unit
- ☐ Body Mechanics Training
- ☐ Strengthening Exercises
- ☐ Aerobics
- ☐ Gravity Inversion – Traction
- ☐ Chiropractic
- ☐ Osteopathy
- ☐ Biofeedback
- ☐ Trigger Point Injections
- ☐ Epidural Injections
- ☐ Back Brace
- ☐ Acupuncture
- ☐ Naturopathy

List the types of Diagnostic Testing that has been performed for this problem

- ☐ X-rays
- ☐ CT Scan
- ☐ Myelogram
- ☐ MRI Scan
- ☐ Discogram
- ☐ Bone Scan
- ☐ EMG
- ☐ Bed Rest

List Past Surgeries: ☐ None

_____
_____
_____
_____

List Past Hospitalizations: ☐ None

_____
_____
_____
_____

List previous back, neck and musculoskeletal problems

_____
_____
_____
_____

Mark if you have had any of the following symptoms in the past 5 years.

☐ Unexplained fevers
☐ Night sweats
☐ Weight loss of 10 lbs or more
☐ Loss of appetite
☐ Excessive fatigue
☐ Problems with depression
☐ Difficulty sleeping
☐ Unusual stress at work
☐ Unusual stress at home
☐ Easy bruising
☐ Excessive bleeding
☐ Lumps in neck, armpit or groin
☐ Chest pain or tightness
☐ Persistent or unusual cough
☐ Trouble breathing with exercise
☐ Trouble breathing lying flat
☐ Coughing up blood
☐ Swollen ankles
☐ Stomach pain
☐ Change in bowel habits
☐ Persistent diarrhea
☐ Excessive constipation
☐ Dark black stools
☐ Blood in stools
☐ Pain-burning when urinating
☐ Difficulty urinating – start / stop
☐ Blood in urine
☐ Need to urinate more at night
☐ Morning stiffness
☐ Persistent eye redness
☐ Muscle tenderness
☐ Dry eyes or mouth
☐ Skin rashes
☐ Joint pain or swelling

Females – Mark if have the following:

☐ Vaginal bleeding other than period
☐ Pap smear within last two years
☐ Painful menstrual periods
☐ Back pain with menstrual periods
☐ Other menstrual problems

Do you have any current problem with:

☐ anxiety
☐ depression
☐ irritability

Do you have a home exercise program that you follow on a regular basis?

☐ Yes ☐ No

Assignment of Benefits In Personal Injury Cases

I authorize **Release Chiropractic and Wellness Center** to receive lien payment from all liable insurance companies, attorneys, or myself for all monies due on my account. I understand that all coverage in effect at the time of my injury will be billed. Any overpayments will be promptly returned to me. In the event that there is no valid coverage or that I have exceeded my insurance limit, I will remain responsible for charges incurred.

Further, I hereby authorize **Release Chiropractic and Wellness Center** or any of their employees to sign my name on the back of any draft or check which they receive from my insurance company for services rendered, whether pursuant to medical payments coverage or health insurance coverage, as long as I have an outstanding balance with them. Said amount shall be credited against my account and shall reduce my outstanding balance accordingly.

All fees are based upon individual services rendered, and may vary from visit to visit depending upon the doctors specific recommendations. A complete list is available at the front desk.

Initial Consultation: This is an opportunity to discuss with the doctor your concerns and their suggestions. There is no charge for this consultation. (The initial consultation does not include any exams, therapy or X-rays).

Note: Unless all proper claim and insurance information is provided, the patient will be responsible for payment of care received after the first visit until the necessary information can be validated.

A charge of $25.00 will be assessed for a missed appointment. This fee will require payment at the next visit. We require a 24-hour notice for cancellations.

If the case is not settled within 120 days of being released from active care, the patient will be responsible to begin making monthly payments until the balance is paid by the insurance company.

I agree to the terms above, and acknowledge that in the event that there is an outstanding balance, which fails to be cured within sixty (60) days, my account with **Release Chiropractic and Wellness Center** will be turned over to collection. I understand that should this happen, I will remain responsible for any and all additional collection fees and/or attorney and court costs.
(Please initial to show your agreement.)

_____
Name

_____ _____
Signature Date

Notice of Doctor's Lien

Patient's Name: _____

Healthcare Provider: Release Chiropractic and Wellness Center
640 East Eisenhower Blvd. Suite 100
Loveland, CO 80537
Phone: 970-667-3393 Fax: 970-203-9690

I hereby authorize the above-mentioned healthcare provider to furnish the below-mentioned attorney with a full report of his/her examination, diagnosis, treatments records, etc., of myself in regard to the accident in which I was involved.

I hereby further authorize and direct you, my attorney to pay directly to said healthcare provider such sums as may be due and owing the office for professional services rendered me both by reason of this accident and by reason of any other bills that are due to the office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said healthcare provider. I hereby further give a lien on my case to said healthcare provider against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said healthcare provider for all professional bills submitted by him/her for services rendered me and that this agreement is solely for said healthcare provider's additional protection and in consideration of his/her awaiting payment. Further, I understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

_____
Name

_____ _____
Signature Date

(Patient, please do not write below this line.)
****

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect the said healthcare provider named above.

Attorney Name: _____

Attorney Address: _____

_____

Date: _____ Attorney's Signature: _____

Please return to: Release Chiropractic and Wellness Center
640 East Eisenhower Blvd. Suite 100
Loveland, CO 80537
Phone: 970-667-3393 Fax: 970-203-9690

Please maintain a copy for your records.

Patient Acknowledgment and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Patient Name: _____

Date of Birth: _____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law, and Federal Law.

Date: _____

By: _____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By: _____
Signature of Parent/Guardian (circle one)