PERSONAL INJURY PATIENT INTAKE FORM

Today's Date: ________________________

Last Name:	**First Name:**	**Middle Initial:**
Mailing Address:	**City:**	**State: Zip:**

Date of Birth: Age:	Social Security Number: - -
Height: Weight:	Who Referred You to Our Office:
Occupation:	Marital Status (Circle): Single, Married, Divorced, Widowed
Cell Phone: ( ) -	Employer's Name:
Home Phone: ( ) -	Work Phone: ( ) -
E-mail Address:	Primary Care Physician:

As a courtesy, we send Appointment Reminders to patients 24 hours before any future appointments. Please let us know whether you would prefer to receive these reminders via text message or email.	☐ Text Message. Cell Phone Carrier: _________________(required) ☐ E-mail (please be sure to provide your email address above) ☐ I would prefer not to receive appointment reminders.

Emergency Contact: ____ Phone: __________________

AUTOMOBILE INSURANCE INFORMATION

Name of Automobile Insurance Carrier:	
Claim Adjustor's Name/Telephone Number:	
Claim Number:	
Have you reported this injury to your insurance?	☐ Yes, ☐ No
Do you have an attorney representing you?	☐ Yes. Name: _______________Phone #:____________ ☐ No.

HIPPA STATEMENT:

As a patient of Center for Chiropractic and Pain Rehabilitation (CCPR), you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the ways in which we secure your information in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Notes taken during appointments are kept in your chart and secured in out clinic at all times. If patient charts are in public areas, the names are covered. Access to the clinic is limited to practitioners and employees. Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc. It is our preference to discuss your health in the clinic setting to protect your privacy and ensure that important information is kept in your chart. Your healthcare information is private and cannot be copied or shared with anyone else without your written signed consent. In some cases, verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax and are accompanied with a confidential patient information cover sheet is faxed. Our office needs to leave messages, return telephone calls, and send office mail to your mailing address as part of our normal practice. Federal/State HIPAA patient privacy laws allow you to restrict doctor/staff communication with you or to contact you through alternative means.

MISSED APPOINTMENT POLICY:

A 24-hour notice is required for all cancellations. A **$40 fee will be charged for all missed appointments.** This fee will not be covered by your group, auto, or personal insurance. If we are closed, please leave a detailed message.

INFORMED CONSENT FOR CHIROPRACTIC CARE:

As a patient at CCPR, I give the doctor of chiropractic (DC) permission and authority to care for me in accordance with the chiropractic tests, diagnosis and analysis s/he performs. The chiropractic adjustments and other clinic procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The DC will not provide treatment if s/he is aware of any contraindications. It is the responsibility of you the patient to make it known to the DC if you have any latent pathological defects, illnesses or deformities that would not be obvious to the DC. I understand that if I am accepted as a patient by a DC at CCPR, I am authorizing him/her to proceed with any treatment deemed to be necessary. The procedures, alternatives and risks involving the treatment will be explained to me prior to the treatment.

______________________________ **Patient Signature** ______________________________ **Date**	I am the responsible party. I have read and understand my right to privacy, as per the above **HIPPA STATEMENT** and agree to have the practitioners and employees of CCPR maintain my records confidentially in accordance with the law. I agree to the above **MISSED APPOINTMENT** and **INFORMED CONSENT FOR CHIROPRACTIC CARE** policies. I agree to pay for any outstanding bills incurred in this office. It is my responsibility to pay any deductible, co-insurance, and/or any other balances not paid by my insurance carrier. CCPR expects payment at the conclusion of each treatment for cash paying patients and the co-payment, co-insurance and/or deductible payments for health insurance patients.

MOTOR VEHICLE COLLISION FORM (Page 1)

Patient Name:____ Date: _______________
Date of collision:_________________________ Time of collision: _____________________ ☐ AM ☐ PM
City where collision occurred: ________________________________ Was the street wet or dry? ☐ Wet ☐ Dry
Street (location) where collision occurred: ____
Who owns the vehicle in which you were hit? ____
What is the estimated repair damage to your vehicle? $______________ ☐ Unknown, ☐ Estimate not done yet
How many people were in your vehicle at the time of the collision? ____________
Did the police come to the accident scene? ☐ Yes, ☐ No
Did the police make a written report? ☐ Yes, ☐ No
Were any photographs taken of the vehicles? ☐ Yes, ☐ No. If yes, who took them? _____________________

DESCRIBE HOW THE COLLISION HAPPENED

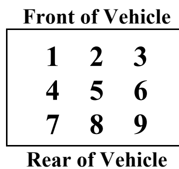
____
____
____
____
____
____

COLLISION DESCRIPTION-TYPE

Check all that apply to you. Indicate which type of automobile collision you were involved in:

☐	Single-vehicle collision	☐	Two-vehicle collision	☐	Three-or-more vehicles
☐	Rear-end collision	☐	Side collision	☐	Rollover
☐	Head-on collision	☐	Hit guard rail, tree, or object	☐	Ran off the road
☐	Other (Describe):				

CIRCLE YOUR SEATING POSITION:



DESCRIBE THE VEHICLE YOU WERE IN (If not certain, check unknown):

Model, Make, and Year: ☐ Unknown

DESCRIBE THE OTHER VEHICLE (If not certain, check unknown):

Model, Make, and Year: ☐ Unknown

AT THE TIME OF IMPACT YOUR VEHICLE WAS:

☐	Slowing down	☐	Gaining speed
☐	Stopped	☐	Moving at a constant or steady speed

AT THE TIME OF IMPACT THE OTHER VEHICLE WAS:

☐	Slowing down	☐	Gaining Speed	☐	Unknown speed
☐	Stopped	☐	Moving at steady speed	☐	Other:

DURING AND AFTER THE COLLISION, YOUR VEHICLE:

☐	Kept going straight, not hitting anything	☐	Spun around, not hitting anything
☐	Kept going straight, hitting car in front	☐	Spun around, hitting another car
☐	Was hit by another vehicle	☐	Spun around, hitting object/curb other than car

MOTOR VEHICLE COLLISION FORM (Page 2)

INDICATE IF YOUR BODY HIT OR WAS HIT BY ANY OF THE FOLLOWING:

Please draw lines from the body regions on the left side and match to the right side.

BODY REGION	OBJECT YOU HAD CONTACT WITH
Head	Windshield or side window
Face	Steering wheel
Shoulder	Side of door
Arm/hand	Dashboard
Front chest wall	Knee bolster/glove compartment
Side chest wall	Direct contact with other vehicle (hood)
Hip/abdomen	Frame/Pillar within vehicle near window
Knee	Roof or top part of vehicle
Leg	Another person sitting in your vehicle
Foot	Other

CHECK ANY OF THE FOLLOWING THAT WERE DAMAGED:

☐ Windshield	☐ Seat bent or damaged	☐ Dash or area around knee/foot
☐ Steering wheel	☐ Side or rear window broken	☐ Other
Describe Damage:		

ALL TYPES OF COLLISIONS *Please indicate those relevant to your case.*

YES	NO	
☐	☐	Did any of the interior front or side structures within your vehicle, such as the side door, dashboard, steering wheel, or floorboard of your car dent inward during the collision?
☐	☐	Did the side door, dash, or interior of your vehicle touch or hit your body during the collision?
☐	☐	Did you strike or did any objects or animals within your vehicle hit you during the collision?
☐	☐	Was the door(s) of your vehicle damaged to a point where you could not open the door?
☐	☐	Did an airbag deploy in your vehicle during the collision? If yes, circle (side airbag/front airbag)
☐	☐	Did you have any cuts, bruises, or abrasions from the airbag deploying?
☐	☐	Did your seatbelt system require repairs after the collision?
☐	☐	Was the seat that your were sitting in damaged or bent during the collision?
☐	☐	If a side impact, did the front of the other vehicle strike the door next to where you were sitting?

SEATBELT USAGE AND STEERING WHEEL HAND PLACEMENT:

YES	NO	
☐	☐	Were you wearing a seatbelt? If yes, does your seatbelt have a: ☐ Lap and Shoulder Strap, ☐ Automatic shoulder strap with driver needing to manually attach lap belt, ☐ Lap belt only
☐	☐	Did you have any portion of your seatbelt positioned behind your chest, back or shoulder.
☐	☐	Did you have any cuts, bruises, or abrasions from the seatbelts?
☐	☐	Were you holding onto the steering wheel (driver only) at the time of impact? If yes, Indicate where each hand was positioned ***(Use time clock face as your reference point)*** Left hand: ☐ Not on wheel, ☐ Yes, hand at ____ o'clock, ☐ Hand elsewhere Right hand: ☐ Not on wheel, ☐ Yes, hand at ____ o'clock, ☐ Hand elsewhere

REAR-END COLLISIONS ONLY

Describe your vehicle's head restraint system:

☐ Movable/adjustable head restraint ☐ Fixed, non-moveable head restraint

☐ No headrests in my vehicle ☐ Bench seat in your vehicle without head restraint

Please indicate how your <u>head restraint</u> was positioned at the time of collision (if present):

☐ At the top of the back of your head ☐ Midway height of the back of your head

☐ Lower height of the back of your head ☐ Located at the level of your neck

☐ Level of your shoulder blades

MOTOR VEHICLE COLLISION FORM (Page 3)

BRUISING AFTER THE COLLISION?

YES	NO	
☐	☐	Did your body have any bruising (areas that were visibly black, red, and/or blue) after the collision? If yes, indicate where bruising was located on your body and what caused the bruising (if known): ______________________________

AWARENESS AND BODY POSITION DESCRIPTIONS: *Check all areas that apply to you.*

☐	You were unaware of the impending collision. You did not see or hear brakes prior to the impact.
☐	You were aware of the impending collision and relaxed before the collision.
☐	You were aware of the impending collision and braced yourself.
☐	Your body, torso, and head were facing straight ahead.
☐	You had your head and/or torso turned at the time of collision: ☐ Turned to left, ☐ Turned to right Describe how far you were turned/twisted and why you were turned/what were you doing?
☐	You were leaning forward at the time of impact resulting in a gap between your body and the seatback. If yes, indicate how far you were leaning and why you were leaning forward?
☐	Your torso/body were positioned normally against the seatback with no gaps due to leaning/twisting.

HAS YOUR PAIN BEEN ASSOCIATED WITH ANY OF THE FOLLOWING?

☐ Excessive fatigue-malaise	☐ Bowel or bladder disorders	☐ Night pain or night time sweats
☐ Weight loss	☐ Ovarian pain	☐ Abdominal pain
☐ Low grade fever	☐ Kidney pain/painful urination	☐ Balance problems

PRIOR INJURY OR PREVIOUS MUSCULOSKELETAL PAIN

(☐ I have no history of previous painful injury or pain) If you have had prior injuries or pain, please check below:

☐ Work Injury	☐ Fall	☐ Sports Injury	☐ Lifting Injury	☐ Car Accident
☐ Motorcycle Injury	☐ Head Injury	☐ Pedestrian Injury	☐ Military Injury	☐ Other Injury
☐ Headaches/Migraines	☐ Neck Pain	☐ Middle Back Pain	☐ Low Back Pain	☐ Shoulder Pain
☐ Arm numb-tingling	☐ Arm Pain	☐ Leg pain-numb-tingling	☐ Other Pain:	

FRACTURES/BROKEN BONES HISTORY

(☐ I have never had any broken bones). If you have broken any bones, indicate where and when below:

Region	Year	Region	Year
☐ Spinal Vertebra		☐ Skull	
☐ Collar bone (clavicle)		☐ Rib bone	
☐ Arm or hand bones		☐ Leg or foot bones	
☐ Pelvis or hip bones		☐ Other: List	

PREVIOUS SURGERIES

(☐ I have never had any surgical procedure). If you have had any previous surgery, indicate type and when:

Surgery	Year	Surgery	Year
☐ Spine Surgery (neck, back, or pelvis)		☐ Appendix or stomach	
☐ Disc surgery in neck or back		☐ Gallbladder/Stomach/Kidney	
☐ Heart		☐ Cancer (any type)	
☐ Head/Brain		☐ Hernia (inguinal or hiatal)	
☐ Shoulder/Arm/Hip/Leg		☐ Other	

ARE YOU TAKING ANY MEDICATIONS?

☐ **I am not taking any medications currently.** Check any of the following that you are taking currently.

☐ Muscle Relaxants	☐ Blood pressure/Stroke prevention medications	☐ Cortisone injections
☐ Pain/Anti-inflammatory meds	☐ Osteoporosis (bone strengthening) medications	☐ Other:

MOTOR VEHICLE COLLISION FORM (Page 4)

HOW SOON DID YOU FIRST NOTICE ANY PAIN/SORENESS AFTER THE COLLISION?

____

____

LIST ALL SYMPTOM REGIONS RELATED TO YOUR MOTOR VEHICLE COLLISION

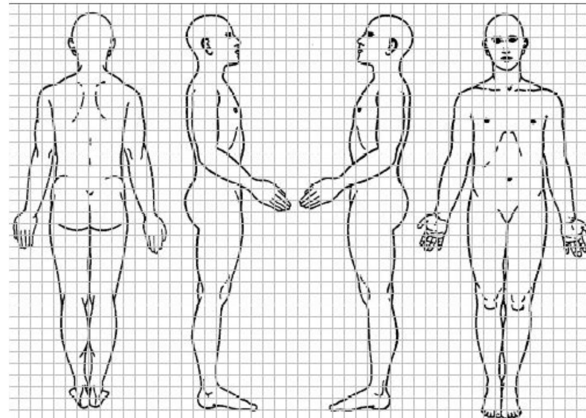
CHECK ALL SYMPTOM AREAS	HOW LONG	CHECK ALL SYMPTOM AREAS	HOW LONG
☐ Headaches/Migraines		☐ Upper Back Pain, Soreness, or Stiffness	
☐ Neck Pain, Soreness, or Stiffness		☐ Hip Pain	
☐ Low Back Pain, Soreness, Stiffness		☐ Leg or Foot Pain, Numbness, or Tingling	
☐ Arm/Hand Pain, Numbness, or Tingling		☐ Knee/Ankle Pain	
☐ Shoulder/Elbow/Wrist Pain		☐ Dizziness/Vertigo	
☐ Jaw Pain		☐ Swelling/Stiffness of Joint(s)	
☐ Excessive Fatigue		☐ Other:	

How severe is your pain? 0 1 2 3 4 5 6 7 8 9 10

No Pain ... **Unbearable Pain**

SYMPTOM/PAIN DESCRIPTION (Please circle any words/areas below that describe your current symptoms.)

Pain	Pinching	Spreading	Stiff or tight	Unbearable
Shooting	Soreness	Pulling	Sickening	Falls asleep
Ache	Tingling	Stabbing	Miserable	Pins and Needles
Tearing	Gnawing	Dull	Pressing	Radiating
Heavy	Nagging	Stinging	Deep pain	Weakness
Irritating	Burning-Hot	Dreadful	Superficial pain	Throbbing
Exhausting	Numbness	Torturing	Sharp	Tender



Please circle or mark with an **X** the areas where you have pain, numbness, tingling or other symptoms.

WHEN IS YOUR PAIN WORSE & WHAT ACTIVITIES INCREASE YOUR PAIN?

☐ Morning is when pain is worse	☐ Bending your back increases pain	☐ Walking increases pain
☐ Afternoon/evening pain worse	☐ Lying down flat increases pain	☐ Standing increases pain
☐ During sleep hours pain worse	☐ Sitting increases pain	☐ Exercise/Stretching increases pain
☐ Standing up from sitting	☐ Poor posture increases pain	☐ Other:

WHAT ACTIVITIES LESSEN YOUR PAIN?

☐ Walking	☐ Being flat on your back	☐ Exercise/Stretching
☐ Sitting	☐ Standing	☐ Other:

DO YOU EXERCISE?

☐ I do no regular exercise	☐ I exercise 1-2 times a week	☐ I exercise 3-5 times a week
☐ I stretch regularly	☐ I do weight lifting at gym/home	☐ I do cardiovascular work outs
☐ I am willing to do exercise	☐ I am not willing to do exercises	☐ I do regular sports activities

MOTOR VEHICLE COLLISION FORM (Page 5)

Check only those conditions that apply to you and indicate if you have had in the past or presently have.

YES	GENERAL QUESTIONS	PAST	PRESENT
☐	Heal slowly or Bruise Easily	☐	☐
☐	Smoke cigarettes or use tobacco products	☐	☐
☐	History of drug or alcohol abuse	☐	☐
☐	Diabetes, hypoglycemia, thyroid disorder, kidney or liver disease, or tuberculosis	☐	☐
☐	Heart attack or have a heart pacemaker or neck or chest shunt?	☐	☐
☐	Currently or recently had any infectious disease such as AIDS, Tuberculosis, etc	☐	☐
☐	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	☐	☐
☐	Do you have problems with dizziness, blacking out, balance, fainting, or tripping	☐	☐
☐	Epilepsy-Seizure-Convulsion history or other neurological disease	☐	☐
☐	History of multiple sclerosis, lupus, psoriasis, temporary paralysis, or meningitis	☐	☐
☐	Cancer history or cancer treatment of any type	☐	☐
☐	Stroke history (Indicate any suspected strokes or transient ischemic attacks)	☐	☐
☐	Told that you have scoliosis, spondylolisthesis, spina bifida, or fused vertebrae	☐	☐
☐	Told that you have a bulging/herniated disc or disc degeneration in the spine	☐	☐
☐	Have you ever been hospitalized? Why:	☐	☐
☐	Blood clots, bleeding or vascular disorder, or told you have an abdominal aneurysm	☐	☐
☐	Hypertension or high blood pressure	☐	☐
☐	Told you have weak bones, osteoporosis, osteopenia, or ankylosing spondylitis	☐	☐
☐	Told you have osteoarthritis, rheumatoid arthritis, or gout of your spine or joints	☐	☐
☐	**Do you have any type of chest or breast implants presently (males & females)?**	N/A	☐
☐	**Women only**: Check box to left if there any chance that you are currently pregnant		

☐ No, ☐ Yes Do you have any problems laying face down on an examination table? If yes, why:_____________________________

Have you ever been to a Chiropractor before for any condition?

☐ No, ☐ Yes If yes, Chiropractor's Name : ____ Year:____________

Problem(s) seen by Chiropractor for: ____

NOTICE OF PRIVACY PRACTICES

We are required by federal and state laws, to maintain the privacy of your health information. We are required to follow the privacy practices as described below. We reserve the right to change this accordance with applicable law. We support your right to the privacy of your health information. You may request a copy of this Notice at any time.

- We may share your health information with a physician or other healthcare provider treating you.
- We may use your health information to obtain payment for services from your insurance company.
- You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting such an authorization in writing. Without your written authorization, we cannot use or disclose your health information for any reason except hose permitted by this Notice.
- In the event of your incapacity or in emergency circumstances, we will disclose heath information to a family member, friend, or other person as necessary only if authorized to do so.
- We will not use your health or personal information (i.e. address & phone number) for marketing purposes.
- We may use or disclose your health information to authorities when we are required to do so by law, including for public health reasons (e.g. disease reporting) if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim or other crimes.
- You have the right to review or receive copies of your health information, with limited exceptions.
- You have the right to request that we amend your health information. Such request must be made in writing, and must explain why the information should be amended. We reserve the right to deny your request.

Please know that there is a fee when your records are specifically ordered by an insurance company, lawyer, or court subpoena. This fee is paid by the requesting party. There is no fee to you for this service or if you request that we send your records to another healthcare provider. Refusal to sign that you have received this information will not affect your treatment, eligibility for benefits or payment.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I (or my legal guardian or parent) acknowledge(s) that I have received and read the Notice of Privacy Practices. The Notice describes the policies and procedures regarding the use and disclosure of my health information that is created, received or maintained by Center for Chiropractic & Pain Rehabilitation.

Name of Patient: ____
Please Print

Name of Guardian/Parent: ______________________ Relationship: ______________________
(If patient is a minor in or under guardianship) Please Print Please Print

Signature of Patient or Guardian/Parent: ______________________ **Date:** __________

FOR OFFICE USE ONLY

Patient was unable or unwilling to sign this document.
Reason: ____

Signed: ______________________________________ Date: ______________