Accident Chiropractic
& Wellness Center

Patient Information

Date_____

First Name:_____ Last Name:_____ Initial:_____

Major Complaint Information

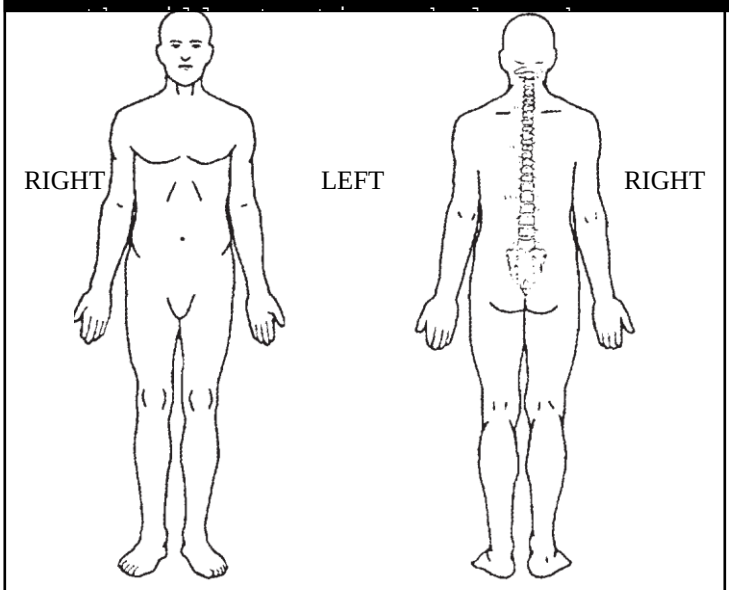
What is your major complaint?_____

When did this symptom(s) begin?_____

If this is an injury, describe what happened:_____

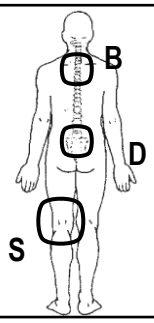
_____

Using the symbols provided in the Pain Index Box, mark the areas



Pain Index

D Dull Nagging Ache
B Burning
S Sharp / Stabbing
N Numbness / Tingling



For example: The image to the left illustrates a burning pain in the neck, a dull ache in the lower back, and sharp pain in the left thigh

What is the pain interfering with that's most important in your life?_____

_____

SEVERITY

On a scale of 0-10, with 0 representing no pain and 10 representing the most severe pain imaginable, use the key to the right and rate the severity of your pain.

Sitting here today, right now, what is the intensity of your pain on a scale of of 0-10? (please circle)

0 1 2 3 4 5 6 7 8 9 10

What is the least intense the symptom has been on a scale of 0-10?

0 1 2 3 4 5 6 7 8 9 10

What is the most intense the symptom has been on a scale of 0-10?

0 1 2 3 4 5 6 7 8 9 10

Have you experienced these symptoms before? ❍Yes ❍No

When?_____

What aggravates this condition?_____

What decreases the symptoms / pain?_____

Key

0 = None
1 = Minimal
2 = Very Mild
3 = Mild
4 = Mild to Moderate
5 = Moderate
6 = Moderate to Severe
7 = Moderately Severe, Restricts some activity
8 = Severe, Limits most activity
9 = Very Severe
10 = Excruciating

CA Initial_____

Have you seen another doctor for this condition? ❍Yes ❍No Doctor's Name:_____

Date Consulted:_____ Diagnosis:_____

Does this condition interfere with your sleep? ❍Yes ❍No If so, how many times do you wake up in pain per night?_____

In what position do you sleep? ❍Back ❍Side ❍Stomach

Do you sleep with a pillow? ❍Yes ❍ No How many?_____

Does heat affect the pain? ❍Yes ❍No If so, how?_____

Does cold affect the pain? ❍Yes ❍No If so, how?_____

Do you wear a heel lift? ❍Yes ❍No If so, which side? ❍Right ❍Left

Does it cause pain to cough, grunt, or sneeze? ❍Yes ❍No If so, where?_____

Check those activities below during you experience difficulty or pain:

❍Lying on back	❍Getting in/out of car	❍Pulling	❍Sitting	❍Standing for long periods
❍Lying on side	❍Dressing self	❍Reaching	❍Bending forward	❍Sneezing
❍Turning over in bed	❍Sexual activity	❍Kneeling	❍Bending backward	❍Coughing
❍Lying flat on stomach	❍Pushing	❍Stooping	❍Walking	❍Other_____

FILL OUT THE NEXT THREE SECTIONS AS THEY APPLY TO YOU

Lower Back Pain

Does pain radiate into the leg? ❍Yes ❍No Where:_____ Does pain radiate to the abdomen? ❍Yes ❍No

Do you ever have impairment of bowel or urinary function? ❍Yes ❍No Explain:_____

Do you have numbness or tingling into the legs/feet? ❍Yes ❍No Explain:_____

Neck Pain

If you have a neck injury, does it affect: (Check all that apply) ❍Hearing ❍Vision ❍Balance ❍Cause ringing in your ears

Do you hear grating sounds? ❍Yes ❍No Do you feel pressure or pain behind your eyes? ❍Yes ❍No

Does pain radiate into the arm? ❍Yes ❍No Where:_____

Do you have difficulty lifting or turning your head? ❍Yes ❍No If so, which direction? ❍Right ❍Left ❍Up ❍Down

Headaches

Do you get headaches? ❍Yes ❍No Frequency_____ Do you have a family history of headaches? ❍Yes ❍No

Do you experience the following along with your headaches: Pain or cracking in your jaw? ❍Yes ❍No

Abnormal blood pressure? ❍Yes ❍No ❍High ❍Low Nausea, Vomiting or Visual Disturbances? ❍Yes ❍No

When was your last eye exam by a doctor? ❍1-6months ❍1-2 years ❍over 2 years

If female, are you pregnant? ❍Yes ❍No ❍Not Sure If no or not sure, date of your last menstrual period:_____

List all medications you are taking now, including over the counter medication:_____

_____

Are you allergic to any medications? ❍Yes ❍No ❍Not Sure Please List:_____

_____

CA Initial_____

Have you ever had any surgeries or hospitalizations? ❍Yes ❍No Please list:

Type of Hospitalization/Surgery:	Date:	Type of Hospitalization/Surgery:	Date:
_____	_____	_____	_____
_____	_____	_____	_____

Have you been x-rayed or received MRI, CT scan in the last 12-18 months? ❍Yes ❍No When?:_____

Have you ever been seen by a chiropractor before? ❍Yes ❍No Please list:

Name of Chiropractor:	Dates:	Name of Chiropractor:	Dates:
_____	_____	_____	_____

Do you have a family physician? ❍Yes ❍No Name of physician:_____

Address:_____

City/State/Zip: _____

Additional Complaints

Please check all additional complaints that you have at this time or have suffered from:

❍Loss of Concentration	❍Neck Stiffness	❍Shortness of Breath	❍Cold Hands	❍Heart Disease
❍Eyes Sensitive to Light	❍Neck Motion Restricted	❍Irritable	❍Cold Feet	❍Arteriosclerosis
❍Memory Loss	❍Upper Back Pain/Stiffness	❍Anxiety	❍Jaw Pain	❍Pace Maker
❍Heavy Feeling of Head	❍Mid Back Pain/Stiffness	❍Depression	❍Hypertension	❍Stroke
❍Dizziness	❍Right / Left Shoulder Pain	❍Insomnia	❍Diabetes	❍Arthritis
❍Ringing in Ears	❍Right / Left Arm Pain	❍Fatigue	❍Convulsions	❍HIV (Aids)
❍Loss of Balance	❍Pins & Needles Arms / Legs	❍Excess Perspiration	❍Allergies (Please list)	❍Alcoholism
❍Loss of Smell	❍Right / Left Leg Pain	❍Digestive Trouble	❍Swollen Joints	❍Ulcers
❍Loss of Taste	❍Low Back Pain / Stiffness	❍Nausea	❍Nosebleeds	❍ProstateTrouble
❍Pain Behind Eyes	❍Sciatica	❍Vomiting	❍Hot Flashes	❍Other (Please list)
❍Vision Problems	❍Scoliosis	❍Diarrhea	❍Excessive Menstruation	_____
❍Sinus Trouble	❍Nervousness	❍Constipation	❍Irregular Cycle	Please Specify Location
❍Fainting	❍Irregular Heart Beat	❍Kidney Infection	❍Cramps	❍Numbness_____
❍PalpitationS	❍Chest Pain	❍Kidney Stones	❍Breast Lump	❍Swelling_____
❍Anemia	❍Bronchitis	❍Frequent Urination	❍Cancer (please specify)	❍Cuts_____
❍Bruise easily	❍Hypo/Hyper Thyroidism	❍Varicose Veins	❍Tuberculosis	❍Bruising_____

Do you have, or have you ever had, any diseases or medical problems not listed? ❍Yes ❍No If so, please list:_____

_____

Have you ever had: ❍**Motor Vehicle Injury** ❍Sports Injury ❍Work Injury ❍Slip and Fall Injury?

If yes, please explain:_____

Is there any additional information you would like the doctor to know before beginning care?_____

_____

Emergency Contact

Name:_____ Relation:_____

Home Phone: ( )_____Work Phone: ( )_____

Address:_____

Personal Information

Address:_____

City / State / Zip:_____

Home Phone: ( )_____Work Phone: ( ) _____

Cell Phone: ( )_____Email:_____

Social Security #:_____ Birth Date:_____ Age:_____ Sex: ❍M ❍F

Occupation:_____Employer's Name:_____

Work Address: _____

City / State / Zip: _____

Marital Status: ❍S ❍M ❍D ❍W Spouse's Name:_____ # of Children:_____

Children's Information:_____

How were you referred to Accident Chiropractic & Wellness Center?_____

_____

Authorization & Assignment

I authorize Accident Chiropractic & Wellness Center to release any information deemed appropriate concerning my physical condition to an insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of an settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charged made for your services.

I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I, the undersigned do hereby appoint Accident Chiropractic & Wellness Center authority necessary to endorse and cash my checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between and insurance carrier and me. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

Date:_____ Patient's Signature:_____

Informed Consent

I hereby authorize physicians and staff at Accident Chiropractic & Wellness Center to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I understand and agree that the amount paid to Accident Chiropractic & Wellness Center for x-rays is for the examination only. The x-ray negatives will remain the property of this office. I further understand that they may be seen by me at any time while I am a patient of this office with proper notification. X-ray negatives that are requested by the patient may be picked up only by the patient but must be returned within 30days.

I certify that the above information in correct to the best of my knowledge. I will not hold my doctor or any staff member of Accident Chiropractic & Wellness Center responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery systems, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care:

Soreness- Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness and discomfort.

Rib Injury- Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns- Heat generated by Physical Therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.

Stroke- Stroke is the most serious complication of the chiropractic adjustment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

Other Problems- There are occasionally other types of side effects associated with chiropractic care. While these are rate, they should be reported to you doctor promptly.
If you have any questions concerning this form or the above statements, please ask your doctor.
Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Date:_____ Patient's Signature:_____

Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient's Name:_____ Birth Date:_____

If you want anyone else to have permission to receive your medical information from this office, please print the name and relationship on the lines below.

_____ _____
Name Relationship

_____ _____
Name Relationship

With my consent, Accident Chiropractic & Wellness Center may call, leave a voicemail, text message, email, or mail information pertaining to appointment reminders, patient statements, insurance information, marketing or office promotions such as birthday calls and newsletters.

_____ _____
Patient (Parent/Legal Guardian if Minor) Signature Date

CA Initial_____