PATIENT # _____

DATE _____

OFFICE USE ONLY

CONFIDENTIAL PATIENT INFORMATION

ACCIDENT REPORT

The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of the form. If you need any help, please ask the receptionist.

PATIENT DATA

(First name, middle initial, last name) **SOCIAL SECURITY #** _____ **DRIVER'S LICENSE #** _____

NAME _____ **HOME PHONE** _____ **EMERGENCY PHONE** _____

HOME ADDRESS _____ **CITY** _____ **ZIP CODE** _____

MAILING ADDRESS _____ **CITY** _____ **ZIP CODE** _____

AGE _____ **BIRTHDATE** _____ **MARITAL: M S W D** **HOW MANY CHILDREN?** _____

OCCUPATION _____ **EMPLOYER** _____

EMPLOYERS' ADDRESS _____ **OFFICE PHONE** _____

NAME OF SPOUSE OR PARENT (circle one) _____ **OCCUPATION** _____

SPOUSE OR PARENTS' EMPLOYER _____ **OFFICE PHONE** _____

PATIENT'S NEAREST RELATIVE (other than spouse) _____ **RELATIONSHIP** _____

RELATIVE'S ADDRESS _____ **CITY** _____ **ZIP CODE** _____

HOW WERE YOU REFERRED TO OUR OFFICE? _____

DATE OF LAST PHYSICAL EXAM _____

WHAT OPERATIONS HAVE YOU HAD & WHEN? _____

SERIOUS ILLNESSES _____

HAVE YOU RETAINED AN ATTORNEY? ☐ **Yes** ☐ **No** **Litigation?** ☐ **Yes** ☐ **No** ☐ **Maybe**

IF SO, NAME AND ADDRESS: _____

WHAT MEDICATIONS OR DRUGS ARE YOU TAKING? _____

WOMEN: ARE YOU PREGNANT? ☐ **YES** ☐ **NO**

INSURANCE DATA:

Name of person (s) responsible for payment _____

Do you have Auto Insurance? ☐ No ☐ Yes Company's Name _____

Please list all sources of insurance:

- Group Insurance _____ (Name) EMPLOYEE I.D. NO. _____
- Spouse's Insurance _____ (Name) POLICY NO. _____
- Workmen's Compensation _____ (Name) GROUP NO. _____
- Others _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. I permit this office to endorse co-issued remittances for the conveyence of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date: _____

Guardian or Spouse's Signature Authorizing Care _____ Date: _____

Information Taken By: _____ Date: _____

—PLEASE COMPLETE THE INFORMATION ON THE REVERSE SIDE ALSO—

HEALTH QUESTIONNAIRE: CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED SINCE YOUR ACCIDENT/INJURY

SYMPTOMS:

HEAD:
- ☐ Headache
- ☐ entire head
- ☐ back of head
- ☐ forehead
- ☐ temples
- ☐ migraine
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Ringing in ears

NECK:
- ☐ Stiff neck
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Pain in neck
- ☐ Neck pain with movement

SHOULDERS:
- ☐ Pain in shoulder joint (R-L)
- ☐ Pain across shoulders
- ☐ Bursitis (R-L)
- ☐ Arthritis (R-L)
- ☐ Can't raise arm
- ☐ above shoulder level
- ☐ over head
- ☐ Tension in shoulders

ARMS & HANDS:
- ☐ Pain in upper arm
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Sensation of pins & needles in arms
- ☐ Sensation of pins & needles in fingers
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Loss of grip strength

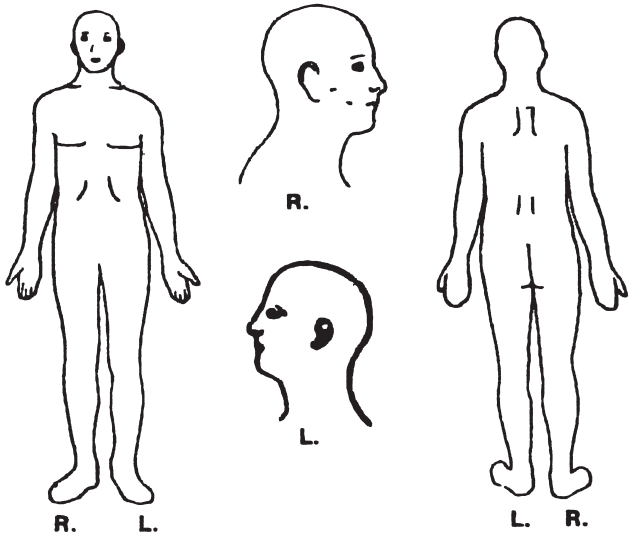
MID-BACK:
- ☐ Mid-back pain
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing pain in mid-back
- ☐ Muscle spasms

LOW BACK
- ☐ Low back pain
- ☐ Low back pain is worse when:
- ☐ working
- ☐ lifting
- ☐ stooping
- ☐ standing
- ☐ sitting
- ☐ bending
- ☐ coughing
- ☐ Low back feels out of place
- ☐ Muscle spasms
- ☐ Arthritis

HIPS, LEGS & FEET:
- ☐ Pain in buttocks (R-L)
- ☐ Pain in hip joint (R-L)
- ☐ Pain down leg (R-L)
- ☐ Pain down both legs
- ☐ Leg cramps
- ☐ Pins & needles in legs (R-L)
- ☐ Numbness of leg (R-L)
- ☐ Numbness of feet (R-L)
- ☐ Numbness of toes
- ☐ Feet feel cold
- ☐ Cramps in feet (R-L)
- ☐ Swollen ankles (R-L)
- ☐ Swollen feet (R-L)

Mark Areas of Pain in Red

Mark Areas of Tingling/Numbness in Blue



CHEST:
- ☐ Chest pain
- ☐ Shortness of beath
- ☐ Pain around ribs

GENERAL
- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally feel run-down
- ☐ Loss of sleep
- ☐ Loss of weight

ABDOMEN:
- ☐ Nervous stomach
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea

Briefly describe symptoms you are presently suffering from: _____

_____

_____

Other Doctors seen for this/these conditions _____

History of present injury - Date: _____ Approximate hour _____ (AM)(PM)

Have you lost any days work? From _____ To _____

If other than auto injury, describe how injury occurred _____

_____

If auto injury fill out the following information: Driver _____ Passenger _____ Front _____ Back _____

Patient's car was going: Direction _____ Street or Road _____

Closest bisecting street or road (if any) _____ Town _____

Numbers of autos involved in accident _____ Number of persons _____

Was patient moving _____ Stopped _____ Turning _____ Right or Left? _____

State exactly where your car was struck (side, rear, front, etc.) _____

Did you see the accident coming? _____ Were seat belts worn? _____

Upon accident, which way were you thrown? _____

Upon impact was there a "blinding" or "explosion" sensation in the head? _____

State which areas of your body were hurt immediately after the accident _____

_____

Were you able to get out of the car and walk? _____

Were you conscious at all times? _____ Could you move all parts of your body? _____

Was a police report made? _____

Was an ambulance called for you? _____ Did you go to the hospital? _____

If so, what was done: X-rays _____ Examination _____ Medications _____

How long were you in the hospital? _____ Were you able to sleep that night? _____

What discomfort did you have the first night? _____

The next day? _____

HIPPA:

Your Health Information Rights:

Although your health record is the physical property of the health care provider or the facility who compiled it, the information belongs to you. You have a right to:

- ⇨ Request a restriction on certain uses and disclosures of your information as provided by CFR 164.522
- ⇨ Obtain a paper copy of notice of information practices upon request
- ⇨ Inspect and copy your health record as provided in 45 CFR 164.524
- ⇨ Amend your health record as provided in 45 CFR 164.528
- ⇨ Obtain an account of the disclosures of your health record.
- ⇨ Revoke authorization for future disclosure except that which has already been provided.

Our Responsibilities:

This Organization is required to:

- ⇨ Maintain privacy of your health information
- ⇨ Provide you with notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- ⇨ Abide by all the terms of this notice
- ⇨ Notify you if we are unable to agree to a requested restriction
- ⇨ Accommodate reasonable requests you may have to communicate health information by alternative means to alternative locations.

We reserve the right to change our practices and make new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the addressed you have supplied.

We will not use or disclose your health information without your authorization, except as described in this notice.

For more information, to report a problem or if you have questions and would like additional information, you may contact our HIPPA Privacy Officer at (334)395-5850. If you believe your privacy rights have been violated, you may file a complaint with our HIPPA Privacy Officer. There will be no retaliation for filing a complaint.

By signing below you verify that you have read and understand the HIPPA Privacy Statement.

Signature_____

Date:_____

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other Chiropractic procedures including various modes of Physical Therapy and diagnostic X-Rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of Chiropractic named below and/or other licensed doctors of Chiropractic who now or in the future, treat me while employed by, working or associated with or serving as back-up for the Doctor of Chiropractic named below, including those working at the clinic or office listed below.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature or purpose of chiropractic adjustments and other procedures.

I understand and am informed that as in practice of medicine, in the practice of Chiropractic there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, as in my best interest.

I have read or have had read to me the above consent. I have also had the opportunity to ask questions about its content and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

TO BE COMPLETED BY PATIENT

Patient Name (Print)_____ Patient Signature_____

Date_____ Witness of Patient's Signature_____

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient Name (Print)_____ Patient Signature_____

Date_____ Signature of Representative_____

Relationship of Authority of Patient's Representative_____

Translated By_____ Date_____