Chiropractic Intake — Auto — 1

Patient Name: ______________________________ Date: ______________ DOB: ______________

PATIENT INFORMATION

Address ______________________________

City, State, Zip ______________________________

Phone (H) ______________ (C) ______________

Email ______________________________

q Male q Female Date of Birth ______________ Age ______

q Married q Widowed q Single q Minor

q Separated q Divorced q Partnered

Employer/School ______________________________

Occupation ______________________________

Spouse's Name ______________________________

Spouse's Occupation ______________________________

IN CASE OF EMERGENCY, CONTACT

Name ______________________________

Relationship ______________ Phone ______________

Who may we thank for referring you? ______________________________

ACCIDENT/DRIVER(S) INFORMATION

Date of Accident ______________________________

Please give a brief description of the crash. ______________________________

____

____

____

Your car insurance company: ______________________________

Adjuster: ______________________________ Phone: ______________________________

Policy #: ______________________________ Claim #: ______________________________

Medical payments coverage amount: ______________ Uninsured motorist coverage amount: ______________

Third party insurance: ______________________________

Name of other driver involved: ______________________________

What law firm represents you? ______________________________

Address ______________________________ City, State, Zip ______________________________

Your lawyer's name ______________________________ Phone: ______________________________

Have you had any other medical care since the crash? If so, describe. ______________________________

Have you lost any work time since the crash? q No q Yes, on these dates ______________________________

Your personal MD's name ______________________________ Phone: ______________________________

HABITS

Smoke q No q Yes ____ pk/day _____ years Alcohol q Never q Social q Light q Moderate q Heavy

EMPLOYMENT

Occupation/job at time of crash ______________________________

Employer ______________________________ q Unemployed

Occupation/job currently ______________________________

Current employer ______________________________ q Unemployed due to crash? q No q Yes

Type of work q Office/clerical q Light labor q Moderate labor q Heavy labor

Chiropractic Intake — Auto — 2

Patient Name: ____________________ Date: ____________ DOB: ____________

MEDICAL HISTORY—PRIOR TO CRASH

Surgeries (dates and residuals) ____________________

Fractures (dates and residuals) ____________________

Serious illness (dates and residuals) ____________________

Workers' comp. injuries (date, TX, awards, residuals) ____________________

Personal injuries (date, TX, awards, residuals) ____________________

Sports or other injuries to head, neck or back ____________________

Any prior episodes of current complaints ____________________

1. ____________________
2. ____________________
3. ____________________

INJURY HISTORY

Date of crash injury/injuries ____________ Were you aware of the impending crash? ☐ Yes ☐ No

Were you the ☐ Driver ☐ Passenger-front ☐ Passenger-rear L/R
☐ Motorcyle operator ☐ Motorcycle passenger ☐ Other ____________

Name of vehicle driver ____________________

YOUR vehicle (year, make, model) ____________________

Does it have a trailer hitch? ☐ Yes ☐ No ☐ Not sure

Your estimated speed at moment of crash ____________ ☐ Stopped ☐ Slowing ☐ Accelerating

OTHER vehicle (year, make, model) ____________________

Estimated speed of other vehicle at moment of crash ____________ ☐ Stopped ☐ Slowing ☐ Accelerating

Road conditions ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Icy ☐ Other ____________

Your head restraint ☐ None ☐ Integral ☐ Adjustable: up/down ☐ Don't know

Was your seat back position altered by the crash? ☐ Yes ☐ No

Was the seat broken? ☐ Yes ☐ No

Were you wearing a lap belt? ☐ Yes ☐ No Shoulder belt? ☐ Yes ☐ No

Did air bag deploy? ☐ Yes ☐ No If yes, were you struck by it? ☐ Yes ☐ No

Body position ☐ Straight forward ☐ Leaning forward ☐ Twisted ☐ Other ____________

Head position ☐ Forward ☐ Left ______° ☐ Right ______° ☐ Up ______° ☐ Down ______°

Hands ☐ One (☐ Left or ☐ Right) on wheel ☐ Two on wheel ☐ Not sure ☐ Not driving

DURING THE CRASH

Location of the crash (street, intersection, city, state) ____________________

____

Damage to your vehicle ☐ Front ☐ Rear ☐ Driver side ☐ Passenger side ☐ Roof ☐ Other ____________

Estimated damage to your vehicle: $ ____________ ☐ Not yet estimated.

Did your body strike any parts of the vehicle? ☐ No ☐ Yes, describe. ____________________

____

Were police on scene? ☐ No ☐ Yes If yes, was a report made? ☐ No ☐ Yes

Chiropractic Intake — Auto — 3

Patient Name: ______________________________ Date: ______________ DOB: ______________

AFTER THE CRASH

Symptoms of: ☐ Headache ☐ Dizziness ☐ Nausea ☐ Confusion/disorientation ☐ Neck pain ☐ Back pain

☐ Numbness/tingling/paresthesia(s) If yes, where? ______________________________

☐ Arm and/or leg pain. If yes, where? ______________________________

☐ Other symptoms? ______________________________

Where did you go after the crash?

☐ Home ☐ Work ☐ Hospital ______________________ ☐ Private doctor ______________________

Mode of transportation ☐ Drove self ☐ Other drove ☐ Emergency transport

TREATMENT HISTORY

Prior to this office, have you been evaluated/treated for these injuries? ☐ No ☐ Yes (list below)

Date ______________ Doctor/Provider ______________________________

Specialty ______________________________

Treatment ______________________________

Date ______________ Doctor/Provider ______________________________

Specialty ______________________________

Treatment ______________________________

Date ______________ Doctor/Provider ______________________________

Specialty ______________________________

Treatment ______________________________

Date ______________ Doctor/Provider ______________________________

Specialty ______________________________

Treatment ______________________________

MEDICAL HISTORY — *office use only*

Request records:

☐ Request radiographs from ______________________________

☐ Request records from ______________________________

☐ Request copy of police report.

Doctor notes: ______________________________

____

____

____

____

Signed ______________________________ Date ______________

Neck Disability Intake

Patient Name: ______________________________ Date: ________________ DOB: ________________

Please read instructions: This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1 — PAIN INTENSITY
- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

SECTION 2 — PERSONAL CARE (Washing, Dressing, etc.)
- ❑ I can look after myself normally, without causing extra pain.
- ❑ I can look after myself normally, but it causes extra pain.
- ❑ It is painful to look after myself and I am slow and careful.
- ❑ I need some help, but manage most of my personal care.
- ❑ I need help every day in most aspects of self care.
- ❑ I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3 — LIFTING
- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights, but it gives extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can lift very light weights.
- ❑ I cannot lift or carry anything at all.

SECTION 4 — READING
- ❑ I can read as much as I want to, with no neck pain.
- ❑ I can read as much as I want to, with slight neck pain.
- ❑ I can read as much as I want to, with moderate neck pain.
- ❑ I can't read as much as I want, because of moderate neck pain.
- ❑ I can hardly read at all, because of severe neck pain.
- ❑ I cannot read at all.

SECTION 5 — HEADACHES
- ❑ I have no headaches at all.
- ❑ I have slight headaches that come infrequently.
- ❑ I have moderate headaches that come infrequently.
- ❑ I have moderate headaches that come frequently.
- ❑ I have severe headaches that come frequently.
- ❑ I have headaches almost all the time.

SECTION 6 — CONCENTRATION
- ❑ I can concentrate fully when I want to, with no difficulty.
- ❑ I can concentrate fully when I want to, with slight difficulty.
- ❑ I have a fair degree of difficulty in concentrating when I want to.
- ❑ I have a lot of difficulty in concentrating when I want to.
- ❑ I have a great deal of difficulty in concentrating when I want to.
- ❑ I cannot concentrate at all.

SECTION 7 — WORK
- ❑ I can do as much work as I want to.
- ❑ I can do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I cannot do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I can't do any work at all.

SECTION 8 — DRIVING
- ❑ I can drive my car without any neck pain.
- ❑ I can drive my car as long as I want, with slight neck pain.
- ❑ I can drive my car as long as I want, with moderate neck pain.
- ❑ I can't drive my car as long as I want, because of moderate neck pain.
- ❑ I can hardly drive at all, because of severe neck pain.
- ❑ I can't drive my car at all.

SECTION 9 — SLEEPING
- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed (less than 1 hr sleepless).
- ❑ My sleep is mildly disturbed (1-2 hrs sleepless).
- ❑ My sleep is moderately disturbed (2-3 hrs sleepless).
- ❑ My sleep is greatly disturbed (3-5 hrs sleepless).
- ❑ My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10 — RECREATION
- ❑ I am able to engage in all my recreation activities, with no neck pain at all.
- ❑ I am able to engage in all my recreation activities, with some neck pain.
- ❑ I am able to engage in most, but not all, of my usual recreation activities, because of neck pain.
- ❑ I am able to engage in few of my recreation activities, because of neck pain.
- ❑ I can hardly do any recreation activities, because of neck pain.
- ❑ I can't do any recreation activities at all.

Instructions: 1. The NDI is scored in the same way as the Oswestry Disability Index.
2. Using this system, a score of 10-28% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.

Oswestry Low Back Pain Scale

Patient Name: ______________________________ Date: ____________________ DOB: ______________

Please rate the severity of your low back pain by circling a number below.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Please circle the **ONE NUMBER** in each section which most closely describes your problem.

SECTION 1 — PAIN INTENSITY

0. The pain comes and goes and is very mild.
1. The pain comes and goes and is moderate.
2. The pain is moderate and does not vary much.
3. The pain comes and goes and is severe.
4. The pain is severe and does not vary much.

SECTION 2 — PERSONAL CARE (Washing, Dressing, etc.)

0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
3. I need some help, but manage most of my personal care.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

SECTION 3 — LIFTING

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights, but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

SECTION 4 — WALKING

0. I have no pain on walking.
1. I have some pain on walking, but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than 1⁄2 mile without increasing pain.
4. I cannot walk more than 1⁄4 mile without increasing pain.
5. I cannot walk at all without increasing pain.

SECTION 5 — SITTING

0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than 1⁄2 hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

SECTION 6 — STANDING

0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than 1⁄2 hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

SECTION 7 — SLEEPING

0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

SECTION 8 — SOCIAL LIFE

0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

SECTION 9 — TRAVELING

0. I get no pain when traveling.
1. I get some pain when traveling, but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling, but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels me to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under 1⁄2 hour.
5. Pain restricts all forms of travel.

SECTION 10 — CHANGING DEGREE OF PAIN

0. My pain is rapidly getting better.
1. My pain fluctuates, but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

TOTAL ____________________

Personal Injury Financial Agreement

Welcome to our office. We assure you that you will receive our very best care for your injury. It's important to familiarize you with our financial policies and we would like to explain the 3 options to handle the cost of your personal injury care.

Option 1: Med Pay

Medical Payments (Med Pay) is a coverage option available with auto insurance policies that covers medical expenses for the policyholder, passengers, and family members traveling in the insured vehicle at the time of an accident. This coverage will pay up to policy limits and regardless of fault. Use of Med Pay does not affect policy premiums. We will bill the Med Pay portion of the auto insurance policy covering the vehicle you were injured in. If the Med Pay benefit is exhausted, you are responsible for payment at that point ***unless*** an attorney is representing you.

Option 2: Attorney Liens

If you have hired an attorney to represent you during your personal injury case, it is our policy to have you and your attorney sign a Chiropractic Lien. This will guarantee direct payment to our office for any unpaid balance upon the settlement of your case in exchange for delaying required payment. Please note that we retain the right to first submit and receive payment from available Med Pay coverage. The amount not covered by Med Pay will be held on the Chiropractic Lien until the case is settled. Further, this office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

Option 3: Self Pay - Third Party Recovery

If you are solely relying on the "at fault" vehicle's insurance to pay your medical expenses, this is termed a "Third-Party" claim. The Third-Party insurance is not obligated to pay our office directly and typically will only reimburse the claimant (you) directly for your medical expenses. Therefore, we ***do not*** bill Third Party insurers. In these cases, if you do not have legal representation, ***you will need to pay for your services (care) at time of service and be reimbursed by the at-fault third party.*** We will provide you with any needed records and receipts. The third party should make any appropriate payment directly to you.

Responsibility for Payment

We will gladly submit records and charges, with your approval and direction, to insurance companies and/or attorneys to help settle your case. However, understand that all services rendered by this office are charged ultimately to you. You are personally responsible for the cost of all services rendered, regardless of any insurance reimbursement or settlement you may or may not receive. Personal health insurance is not billed in personal injury claims, it is not a responsible payer in personal injury claims. We will not bill your personal health insurance.

Voluntary Termination of Care

If you suspend or terminate your care at any time, your portion of all charges for professional services provided becomes immediately due and payable to this office.

I have read and understand the above.

______________________________ Patient (or Legal Guardian) Signature

______________________________ Date

______________________________ Patient's Name Printed

______________________________ Witness

Lien

Patient Name: ____ Date: ____________________

Date of Accident: ______________________________ Date of Birth: ________________________________

I do hereby authorize **Family First Chiropractic** and associated Doctors, to furnish you, my attorney, with a full report of the Doctor examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor/facility such sums as may be due and owing him/them for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office/facility and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor/facility against any and all proceeds of my 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 doctor and facility for all medical bills submitted by him/them for service rendered me and that this agreement is made solely for said doctor's/facility's additional protection and in consideration of his/their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor/facility of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's/facility's interest, the doctor/facility will not await payment but may declare the entire balance due and payable.

______________________________ ______________________________

Patient Signature Date

The undersigned, being attorney of record for the above patient, does hereby agree to observe all terms of the above and agrees to withhold such sums for any settlement, judgment, or verdict, as may be necessary to adequately protect Family First Chiropractic in consideration for one copy of records at no expense.

______________________________ ______________________________

Attorney Signature Date

Please date, sign and return to Family First Chiropractic.

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: ________________________________Last Name: ______________________________

Preferred Language: _______________ D.O.B.___/____/_______ Sex: _________

Sex at Birth:______________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity If yes, start date:____________

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

☐ I choose to decline receipt of my clinical summary after every visit.

Patient Signature:____ Date: ________________

For office use only
Height: ________ Weight: _________ Blood Pressure: _______/_______ Pulse:________

Patient Name: ______________________________ DOB: __________________ Date: ______________

Consent for Care

The process of determining suitability of Chiropractic Services involves answering fully and truthfully all questions presented to you either written or spoken regarding your past and present health conditions during the Consultation.

If warranted, a physical examination will be performed that can include but is not limited to: vitals measurement, systems evaluation, orthopedic tests and maneuvers (tests that move and stress joints of the body), neurological test (tests using sharp or dull instruments, smells or sounds, gently tapping tendons) as well as physical touching. These test and maneuvers will help the Chiropractor determine what may be causing your complaints. Occasionally some temporary soreness and/or stiffness may occur due to the examination; less frequently aggravation of presenting symptoms or initiation of new symptoms.

Radiographs (X Rays) may be taken or ordered to further the Chiropractor's understanding of the underlying condition, positions and alignment of the spine and associated structures. There is limited but present risk to radiation exposure. If you are or think you may be pregnant alert the Chiropractor and/or X ray lab technician; X Rays are not allowed to pregnant women in any trimester.

Privacy Notice Acknowledgment

We are concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I consent to the performance of the above-mentioned procedures performed by the doctor involved in my case: ____ YES _____ NO

I acknowledge that I have been offered a copy of Family First Chiropractic's *Notice of Privacy Practices for Protected Health Information.*

Patient Signature: ____ Date:________________

Witness Signature: ____Date:________________