Woodlake Chiropractic

COMPREHENSIVE ACCIDENT HISTORY

Today's Date: _____ Injury Date : _____

INSTRUCTIONS: Please complete the following information in its entirety. The information submitted on this form is strictly confidential. If you have difficulty understanding any portion of this, please ask the receptionist for assistance. If the question does not pertain to you, simply write in N/A for non-applicable.

PERSONAL INFORMATION

Patient Full Name: _____
Address: _____ City:_____ State: _____ Zip: _____
Birth Date: _____ Age: _____ Marital Status: _____
Gender: _____ Home Phone: _____ Cell Phone: _____
Social Security Number: _____ Email Address: _____
Spouse's Name:_____ Is your spouse a patient in our office? ( )Yes ( )No
Employment Status: ( )Employed ( )Unemployed ( )Full Time ( )Part Time ( )Student ( )Other _____
Business Name: _____ Occupation/Job Title: _____
Business Address: _____
Business Phone: _____ Type of Work: _____
IS it ok to contact you at work? ( )Yes ( )No

Emergency Contact Information

Name: _____
Address: _____ City:_____ State: _____ Zip: _____
Relationship: _____ Home Phone: _____ Cell Phone: _____

Insurance Information

AUTO ACCIDENT INSURANCE INFORMATION: If you have not completed an application of benefits from your auto carrier, you must do so for charges to be covered.

Auto Insurance Carrier: _____
Auto Insurance Carried Phone: _____ Ext: _____
Insurance Carrier Address: _____
Claim Adjuster's Name: _____ Claim Number :_____

AUTO ACCIDENT HISTORY

WELCOME: The doctor and staff welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will refer you to the appropriate healthcare provider. If you are a candidate for chiropractic care; a treatment plan will be recommended to fit your individual needs.

INSTRUCTIONS: Please complete questions to the best o your ability. Be as descriptive as possible and check all descriptions that apply. If you have questions, please ask a staff member for assistance or clarification. Please inform the doctor if there are circumstances surrounding your accident that are not covered here and that you feel would be helpful.

HISTORY OF OCCURRENCE

1. I was the/a:
   a. What was your point of impact? _____
   b. Did you feel pain immediately following the accident? _____
      If you answered no how long after the accident was it before the pain started? _____days
   c. Where did you go after the accident? _____
   d. How did you get there?_____
   e. List any Doctors you've seen prior to this first visit to our office, their specialty, and any treatments received:_____

      _____

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2. Patient Vehicle Type: _____
3. Second Vehicle Type: _____
4. Third Vehicle Type: _____
5. Road Conditions: _____
6. Road Type: _____
7. Were you aware the accident was going to occur? _____
8. Were you wearing a seatbelt? _____
9. Did your airbag deploy? _____
10. Does your car have a headrest? _____
11. What position was the headrest in? _____
12. Head position: _____
13. Were you pushing the brake(stopping) either during or before impact? _____
14. Was your car moving before the impact?_____ If Yes, how fast?_____ (mph)
15. Was the driver of the second vehicle braking(stopping)? _____
16. Was the second vehicle moving before impact? _____ If Yes, how fast?_____ (mph)
17. Was the driver of the third vehicle braking(stopping)? _____
18. Was the third vehicle moving before impact? _____ If Yes, how fast? _____ (mph)

COLLISION DETAILS *(Describe how the cars collided, My vehicle was…)*

19. First Impact: (My car was hit in the…)_____
_____
20. Second Impact: (My car was hit in the…)_____

COLLUSION RESULTS ("During the accident my…")

21. Body was thrown: _____
22. Head Hit: _____
23. Chest Hit: _____
24. Shoulders Hit: _____
25. Knees Hit: _____
26. Hips Hit: _____

If other area than describe:_____

VEHICLE DAMAGE

27. First Vehicle: _____
28. Second Vehicle: _____
29. Third Vehicle: _____

PERSONAL INJURY

30. Were you hospitalized? *(If yes, please answer the questions in the paragraph below.)*
    When were you hospitalized? Date: _____
    How were you transported to the hospital? _____
    What did the hospital recommend? _____
    Did you have any x-rays, CT Scans or MRI's taken?_____ If Yes, what areas? _____
31. List all your symptoms/complaints/conditions here: _____
    _____
32. Describe the quality of your symptoms: _____
    _____
33. How would you describe your current symptoms: _____
    _____

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On a scale of 0 to 10, zero being the lowest level and ten being the highest, how would you rate the effect on your condition or pain has:

34. on your daily functioning when you are at rest? _____
35. on your daily functioning when you are active? _____
36. When did this condition originally begin? _____
37. Is your condition currently worsened or worsening? _____
38. If your condition has worsened or is worsening, when did the increased symptoms start? _____
39. When was the last time you experienced these symptoms? _____
40. Is your condition worse in the : _____
    And is it mostly: _____
41. Is your condition better in: _____
42. Is your condition worse in: _____
43. Check any of the following signs or symptoms that are associated with your current condition:
    Headaches (Describe your headaches in detail):_____
    (Describe the location and type of sensation): _____
    Weakness (Describe the location): _____
    Other not listed (Describe): _____
44. Do your symptoms seem to be better with: _____
    _____

PAST HEALTH HISTORY

This section will identify key factors and will identify key factors and indicators about your history that may impact or contribute to your current health condition. Please give us information on any below that apply to you.

45. Please list any medications or nutritional supplements that you are currently taking: _____
    _____
46. Please list any other doctors or providers that you have seen for this condition or for any conditions that you may be currently treating and the type of treatments provided:_____
    _____
47. Childhood Illnesses (Please list any illnesses that you have had as a child): _____
    _____
48. Adult Illnesses (Please list any illnesses that you have currently or had): _____
    _____
49. Surgeries (Please list all surgical procedures that you have had in the past): _____
    _____
50. Injuries (Please list any significant injuries, falls, trauma, accidents that you have had in the past): _____
    _____
51. Immunizations (Please list any vaccinations that you have had): _____
    _____
52. Non Drug Allergies and how you react to those substances: _____
    _____

FAMILY HISTORY

This section will identify any possible genetic characteristics or risk factors that may impact or contribute to your current health condition.

53. Please describe your family history:

General Family:_____
Father: _____
Mother: _____
Paternal Grandfather: _____
Paternal Grandmother: _____

Maternal Grandfather: _____
Maternal Grandmother: _____
Sister(s): _____
Brother(s): _____
Son(s): _____
Daughter(s): _____
Additional: _____
_____

SOCIAL & WORK HISTORY

This section identifies key factors and indicators about your lifestyle that may impact or contribute to your current health condition. Please check as many as apply.

54. Please describe your alcohol use: _____
    How much alcohol do you regularly drink? _____
55. Please describe your average your diet: _____
56. What is the highest education level you have attained? _____
57. Have you ever used illegal substances or IV drugs? _____
58. Please describe your tobacco use: _____
59. Please describe your condition's effect on your activities of daily living (ADL's):
    Caring for Infirm Family :_____
    Carrying Groceries: _____
    Change Position (Sit to Stand): _____
    Climbing Stairs: _____
    Daily Pet Care: _____
    Driving: _____
    Extended Computer Use: _____
    Household Chores: _____
    Lifting Children: _____
    Self Care-Bathing: _____
    Self Care-Dressing: _____
    Self Care-Shaving: _____
    Sexual Activities: _____
    Sleeping: _____
    Static Sitting: _____
    Static Standing: _____
    Walking: _____
    Yard Work: _____
60. Please list any recreational activities or hobbies and describe your condition's effect on those activities:
    List: _____
    List: _____
    List: _____
61. Please describe your current employment status: _____
62. How would you classify your job based on the following lifting limits? _____
63. How often do you lift at your job? _____
64. Lifting Postures: _____

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65. How many hours per day do you do each of the following activities?
    Sitting: _____ Standing: _____ Walking: _____ Climbing: _____ Pushing: _____ Pulling: _____
    Kneeling: _____ Reaching: _____ Twisting: _____
66. If you lift at work, what type of lifting is most frequent? _____

67. Please describe your condition's effect on your job performance: _____
_____
_____
_____

Is there any other information that you feel would be relevant to your current condition that was not covered? Please explain in the following section any information that you feel would be helpful to the doctor in reviewing your case.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Signature: _____ Date: _____

Photo Consent

I give permission to Woodlake Chiropractic doctors and staff to use my photographs, videos and any handwritten/emailed testimonials from me for advertising purposes both internal and external. This would include but is not limited to; newsletters, print ads, websites, in office use, and any other promotional item for the office. Should I request to have my photos, videos or written testimonials removed, I will inform the doctors in writing.

_____ _____

Signature of Patient or Guardian Date

X-Ray Consent

I hereby give my consent to Woodlake Chiropractic and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge; I am not pregnant. I have read and understood all the above information.

_____ _____

Signature of Patient or Guardian Date

Terms of Acceptance

It is essential that the patient seeking chiropractic care and the chiropractic whom they select are both working towards the same therapeutic goal. Below we outline our objective and our method in order to prevent confusion or disappointment.

Subluxation is a misalignment of one or more of the joints in the body. This can cause pain or altered nerve function that interferes with the body's innate ability to maintain health.

An **Adjustment** is the specific application of forces to facilities the body's correction of subluxation. Our chiropractic method of correction utilizes specific manual and instrument-assisted adjustments to the spine, other joints in the body, and the nervous system to assist the body in returning to a state of maximum health. Modalities such as exercise, stretching, and soft tissue therapies may be used to achieve the optional well-being of the patient.

Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease.

Financial Policies

PAYMENT IS DUE AS SERVICE IS RENDERED

However, as a courtesy to our patients, we do allow other payment options within guidelines of our policy.

1. CASH: We accept cash, check, Visa, Mastercard, American Express, and Discover. Payments for services are due at the time the services are rendered unless payment arrangements have been approved in advance by our staff. Returned checks maybe subject to a $15.00 service charge additional to penalties incurred by the banking institution. Savings plans are available for children, families, and adults desiring regular treatments.
2. GROUP INSURANCE: Patients are responsible for payment in full at the time of and for the first visit. If out of network, the patient is responsible for submitting all claims to their insurance company for reimbursement.
3. WROKER'S COMPENSATION: Patients are required to fill out a worker's compensation questionnaire. When verification has been completed and the proper forms are filed, we will accept assignment on work related cases.
4. ACCIDENTAL/PERSONAL INJURY: Patients are required to complete a personal injury questionnaire and/or an accident report form. If you have been involved in a motor vehicle accident, it is important that you report the accident to your insurance agent. You must ask for a claim number and obtain the appropriate billing information. If an attorney is involved, please let us know.
5. MEDICARE: We will submit al claims to Medicare for you. You are responsible for payment of all services at the time of service. This would include x-rays, examinations, adjustments, supports, nutrition, and therapy. You must provide your Medicare card at the first visit. If you have a secondary insurance, we will bill Medicare, but you are responsible for submitting any unpaid balance to your secondary insurance.
6. MEDICAL ASSISTANCE: We do no accept assignment for Medical Assistance in our office. Savings plans are available for people on social security.

Acknowledgment of Receipt of Privacy Practices

I, _____, acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Woodlake Chiropractic which describes the practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the practice.

If you have any questions or comments regarding our terms, policies, we are happy to assist you.

_____ _____ _____

Name of Patient Signature of Patient or Guardian Date