

# MOTOR VEHICLE ACCIDENT HISTORY

PATIENT NAME:		DATE:	
ADDRESS:		CITY:	STATE/ZIP CODE:
HOME PHONE NUMBER:		CELL PHONE NUMBER:	
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	AGE:	GENDER:
EMERGENCY CONTACT NAME:		EMERGENCY CONTACT PHONE NUMBER:	
EMPLOYER NAME:		EMPLOYER ADDRESS:	
<b>ACCIDENT INFORMATION</b>			
DATE OF ACCIDENT:	TIME OF ACCIDENT:	WHERE WERE YOU LOCATED IN THE VEHICLE AT THE TIME OF THE ACCIDENT? <input type="checkbox"/> DRIVER <input type="checkbox"/> PASSENGER <input type="checkbox"/> FRONT SEAT <input type="checkbox"/> BACK SEAT	
NUMBER OF PEOPLE IN THE CAR:	WERE YOU WEARING A SEATBELT?		
WHAT DIRECTION WAS YOUR CAR HEADED? <input type="checkbox"/> NORTH <input type="checkbox"/> SOUTH <input type="checkbox"/> EAST <input type="checkbox"/> WEST		ON WHAT STREET WERE YOU HEADED?	
WHAT DIRECTION WAS THE OTHER CAR HEADED? <input type="checkbox"/> NORTH <input type="checkbox"/> SOUTH <input type="checkbox"/> EAST <input type="checkbox"/> WEST		WERE YOU STRUCK FROM: <input type="checkbox"/> BEHIND <input type="checkbox"/> FRONT <input type="checkbox"/> LEFT SIDE <input type="checkbox"/> RIGHT SIDE	
WERE YOU KNOCKED UNCONSCIOUS? <input type="checkbox"/> YES <input type="checkbox"/> NO		DID YOU HIT YOUR HEAD? <input type="checkbox"/> YES <input type="checkbox"/> NO	
WHERE WERE YOU TAKEN AFTER THE ACCIDENT?			BY AMBULANCE: <input type="checkbox"/> YES <input type="checkbox"/> NO
WERE THE POLICE ON THE SCENE? <input type="checkbox"/> YES <input type="checkbox"/> NO	WAS A REPORT FILED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOU HAVE A COPY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
HAVE YOU BEEN TREATED BY ANY OTHER DOCTORS FOR THIS ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		SINCE THE INJURY, ARE YOUR SYMPTOMS: <input type="checkbox"/> IMPROVING <input type="checkbox"/> GETTING WORSE <input type="checkbox"/> GETTING BETTER	
HAVE YOU LOST TIME FROM WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE YOU LEFT WORK:	DATE YOU RETURNED TO WORK:
HAVE YOU BEEN INVOLVED IN AN ACCIDENT IN THE PAST? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE DESCRIBE:	
DO YOU HAVE ANY PREVIOUS ILLNESSES WHICH RELATE TO THIS CASE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE DESCRIBE:	
DO YOU HAVE ANY ACTIVITY RESTRICTIONS AS A RESULT OF THIS INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE DESCRIBE:	
<b>INSURANCE INFORMATION</b>			
AUTO INSURANCE COMPANY NAME:			
ADJUSTER NAME:		ADJUSTER PHONE NUMBER:	
POLICY NUMBER:		CLAIM NUMBER:	

ACCIDENT INFORMATION

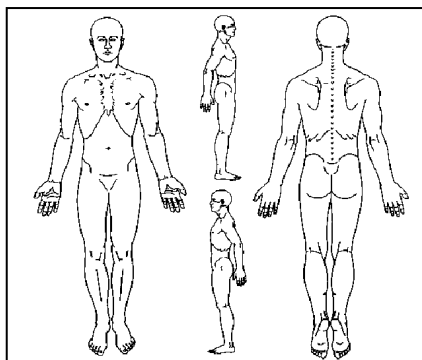
EXPLAIN THE ACCIDENT IN YOUR WORDS:

INSTRUCTIONS: Check (✓) any/all symptoms noted after the accident.

- HEADACHE
- NECK PAIN
- NECK STIFFNESS
- SLEEPING PROBLEMS
- BACK PAIN
- NERVOUSNESS
- TENSION
- IRRITABILITY
- CHEST PAIN
- DIARRHEA
- CONSTIPATION
- FEVER
- DIZZINESS
- HEAD SEEMS HEAVY
- PINS & NEEDLES IN ARMS
- PINS & NEEDLES IN LEGS
- NUMBNESS IN FINGERS
- NUMBNESS IN TOES
- SHORTNESS OF BREATH
- FATIGUE
- DEPRESSION
- FEET FEEL COLD
- HANDS FEEL COLD
- COLD SWEATS
- LIGHT BOTHERS EYES
- LOSS OF MEMORY
- EARS RING
- FACE FLUSHED
- RINGING IN EARS
- LOSS OF BALANCE
- FAINTING
- LOSS OF SMELL
- TROUBLE SWALLOWING
- UPSET STOMACH
- OTHER: \_\_\_\_\_
- OTHER: \_\_\_\_\_

INSTRUCTIONS: Please mark the area and type of pain on the drawings using the codes listed below:

N=Numbness P=Pain A=Ache T=Tingling S=Stiffness/Soreness



COMMENTS:

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PLEASE PROVIDE ANY OTHER PERTINENT INFORMATION YOU THINK WE SHOULD KNOW:

DOCTOR ONLY

DOCTOR COMMENTS:

SIGNATURE

PATIENT SIGNATURE:

DATE:

## AUTHORIZATION FOR CARE / TERMS OF ACCEPTANCE

*I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.*

*I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.*

*As with any healthcare procedure, there are certain risks which may arise during chiropractic care. We will make every reasonable effort during the examination to screen for contraindications to care; if you have a condition that would otherwise come to my attention, it is YOUR responsibility to inform the doctor.*

**Ownership of X-ray Films:** *It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.*

*When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.*

*An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.*

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

*Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of the nerve function and interference of the transmission of the nerve impulses, lessening the body's innate ability to maintain maximum health.*

*We do not offer to diagnose or treat any disease or condition other than the vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.*

*I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.*

SIGNATURE:	DATE:
GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE:	DATE:

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

PATIENT    
  SPOUSE    
  PARENT    
  WORKERS COMP    
  AUTO INSURANCE    
  MEDICARE    
  HEALTH INSURANCE

## NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

*I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:*

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

*I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.*

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE:

ADDITIONAL NOTES: