Motor Vehicle Accident History

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Patient Name:			Date:
Address:		City:	State/Zip Code:
Home Phone:		Cell Phone:	
Work Phone:		Emergency Contact and Phone:	
Social Security Number:	Date of Birth:	Age:	Gender:
Employer Name:		Employer Address:	

ACCIDENT INFORMATION

Date of accident:	Time of accident:	Where were you located in the vehicle at the time of the accident? ☐ Driver ☐ Passenger Front seat ☐ Back seat
Number of people in the car:	Names of people in the car with you:	
What direction was your car headed? ☐ North ☐ South ☐ East ☐ West		Were you struck from: ☐ Behind ☐ Front ☐ Left side ☐ Right side
Were you knocked unconscious? ☐ Yes ☐ No		Did you hit your head? Yes No
Where were you taken after the accident?		By ambulance: ☐ Yes ☐ No
What were the weather conditions during the accident?		Did the airbag deploy? ☐ Yes ☐ No
Speed the vehicle(s) were traveling?		Were you wearing a seatbelt? ☐ Yes ☐ No
Since the injury, are your symptoms: Improving Getting worse Getting better		
Were the police on the scene? ☐ Yes ☐ No	Was a report filed? ☐ Yes ☐ No	Do you have a copy? ☐ Yes ☐ No
Have you been treated by any other doctors for this accident? ☐ Yes ☐ No		What treatments were given?
Have you lost time from work? ☐ Yes ☐ No	Date you left work:	Date you returned to work:
Have you been involved in an accident in the past? ☐ Yes ☐ No	If yes, please describe:	
Do you have any previous illnesses which relate to this case? ☐ Yes ☐ No	If yes, please describe:	
Do you have any activity restrictions as a result of this injury? ☐ Yes ☐ No	If yes, please describe:	

INSURANCE INFORMATION

Auto insurance company name:	Adjuster phone number:

"The doors we open and close each day, decide the lives we live."

Adjuster name:	
Policy number:	Claim number:

ACCIDENT INFORMATION

Describe the accident in your own 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
- ☐ buzzing in ears
- ☐ loss of balance
- ☐ fainting
- ☐ loss of smell
- ☐ loss of taste
- ☐ upset stomach
- ☐ other
- ☐ other

Please provide any other pertinent information you think we should know:

DOCTOR ONLY

Doctor comments:

SIGNATURE

Patient signature:	Date:

HIPAA INFORMATION

The following office procedures allow ______________ Chiropractic to operate in an efficient manner and allow us to support our practice members with their care. By signing below you are giving us authorization to follow through with these procedures. ***Should you desire something not to be done, place a check in the box next to anything you refuse and initial.***

☐ ______ We may need to contact you by telephone or text at home or at work regarding appointments and other matters related to care/appointments in this office.

☐ ______ We may need to leave a message with another person (spouse, co-worker) or on an answering machine/voicemail at home or at work regarding appointments and other matters related to care in this office.

☐ ______ We routinely have mailings (including postcards) from our office sent to you at home or email address.

☐ ______ We acknowledge and think everyone who refers friends or family members to our office for chiropractic care. We would like to directly thank the person who referred you and use your name.

You have the right to refuse any of this authorization without affecting your care or the relationship with anyone at _______________ Chiropractic. This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.