Integrative Healthcare Partners Auto Accident # _____

First Name _____ Middle Initial _____ Last Name _____

_____

Home Address City State Zip code

Email address _____ S.S.# _____

Date of Birth _____ Age _____ Male or Female _____

Please circle one: Single Married Separated Divorced Widowed

Home phone # _____ Cell phone # _____ Work phone # _____

Medical Doctor Name _____ Phone # _____

Preferred Pharmacy Name _____ Phone # _____

Employer _____ Occupation _____ Employer Address: _____

In case of emergency contact _____ phone # _____

Nearest relative not living with you _____

Home # _____ Cell # _____

Please name the person who referred you here _____

You will receive a statement once a month until your bill is paid in full

We will not bill third party insurance (office policy)

I authorize the use of this information for insurance billing, the release of information to the insurance company, I am responsible for my charges for services, and authorize payment to Spine & Neuromuscular Assoc. of S.E.I., P.S.C., and permit a copy of this authorization to be used in place of the original. Your insurance policy is between you and your insurance company. We will file your claims as a courtesy to you however; you are ultimately responsible for all bills and may be responsible for out of network charges and deductibles. Co-payments are due at the time of service. We accept cash, personal checks, Visa, Master Card, and American Express. The fee for returned checks is $25 cancellation of less than 24 hr. notice or "NO SHOWS" WILL BE BILLED an office visit charge of $75 that is not covered by insurance and must be paid before further services are provided by our practice subject to the discretion of the practice.

INSURANCE AUTHORIZATION, ASSIGNMENT OF BENEFITS AND HIPAA NOTICICATION

I authorize payment of medical benefits directly to the provider(s) who have treated me or rendered services or materials. My signature below also serves as my consent to treatment and verifies that I have received a copy of this practice's HIPAA policy and Required Disclosure for Medicare Conditions of Coverage for any physician owned entity where this practice delivers care and that any questions that I may have concerning these documents have been adequately answered.

Signed _____ Date _____

Patient Name _____ File # _____

NATURE OF ACCIDENT

Date of accident _____Time of accident _____State of accident _____

Explain accident details in full _____

_____

_____

List the type of vehicle you were in: Year _____Make _____Model _____

What is the estimated cost of damage to your vehicle? _____

List the type of vehicle other driver was in: Year _____Make _____Model _____

Was your car stopped at time of impact? _____

On what part of the automobile did your following body parts hit?

Head hit the _____Chest hit the _____

Right/Left shoulder hit the _____Right/Left arm hit the _____

Right/Left hip hit the _____Right/Left leg hit the _____

Right/Left knee hit the _____Other_____

What bruises did you sustain during this accident? _____

Did you lose consciousness upon impact? _____ Were you wearing a seat belt? _____

Did the police come to the scene of accident? _____Was a report made? _____

Did you go to a hospital? _____If yes, name of hospital_____

How did you get to the hospital? _____

What areas of your body were x-rayed? _____

How long did you stay at the hospital? _____

Besides ER/Hospital care have you seen any other health care providers for your injuries? _____

Who & when _____

Have you missed any work because of your accident? _____

Have any diagnostic tests been ordered since your accident? _____
examples: MRI, EMG, CT Scan, If so where? _____

Patient Name _____ **File#** _____

Before the accident were you having any similar symptoms? _____ **If yes,**

please list similar symptoms _____

Please list any other past conditions or injuries we should be aware of: _____

_____

_____

Case History

Please list your Chief Complaints:

- _____
- _____
- _____

Do you feel your symptoms are mild, moderate, or severe? _____

What worsens your symptoms? _____

What makes your symptoms better? _____

Are your symptoms: **Constant** **Progressive** **Intermittent**

Have you had the *same or similar symptoms* in the past? Y / N If so please explain

_____

Have you had any prior treatment or testing regarding this problem? _____

_____

Have you had any past injuries we should know about? _____ **Please list**

the year and type of injury _____

Do your symptoms interfere with daily living? Y or N, with your sleep? Y or N

Do your symptoms interfere with your lifestyle? Y or N, with your work? Y or N

Please list *all medications* you are currently taking _____

_____

Please list *all surgeries* you've ever had (including breast implants) _____

_____

File # _____

Have you had any past illnesses you feel are significant? _____

_____

Family history of illness? Example: Dad-diabetic, Mom-high B/P, Sister-scoliosis

_____

_____

Father's age _____or Cause & age at death_____

Mother's age _____or Cause of age at death_____

Are you single, married, divorced? _____ Number of children? _____

Alcohol use: none rarely social drinker abuses recovering alcoholic_____

Tobacco use: none cigarettes cigars pipe chew dip Quit _____

Do you exercise? None—occasional—regularly—type of exercise_____

Circle the highest level of education completed: High School College Post Graduate

<u>Please circle the condition that describe your work environment</u>
Loud—Lung Pollutant—Extreme Hot/Cold—Constant Sitting—Constant Standing

Requires Lifting—Heavy Data Entry—Stressful No Problems

Have you experienced any recent traumas such as divorce, death of family or friend,

job loss, change in residence? _____

_____

Please circle your race: Asian Black Hispanic White Other_____

Have you been treated by a chiropractor before? _____ Dr._____

Were your results satisfactory? _____

Women Only - Is there any chance you are currently pregnant? _____

I have read the above information and answered to the best of my ability.

Date _____ Signature _____

Please put a check mark by each condition you have experienced recently

FATIGUE _____ JOINT PAIN _____

HEADACHES _____ STIFF NECK _____

INFLAMMATION _____ NUMBNESS _____

MUSCLE ACHE _____ MUSCLE CRAMPS _____

MUSCLE SPASM _____ MUSCLE WEAKNESS _____

SORENESS _____ STIFFNESS _____

TENDERNESS _____ ABNORMAL POSTURE _____

ARTHRITIS _____ DISABILITY _____

FRACTURE/DISLOCATION _____ BLADDER INFECTION _____

DIARRHEA _____ CONSTIPATION _____

RECENT TRAUMA _____ SPRAIN _____

NUMBNESS IN ARMS _____ NUMBNESS IN LEGS _____

NERVOUSNESS _____ IRRITABILITY _____

SLEEPING DISORDER _____ SHORT of BREATH _____

HIGH BLOOD PRESSURE _____ DEPRESSION _____

TENSION _____ SCOLIOSIS _____

LOSS OF MEMORY _____ LOSS OF BALANCE _____

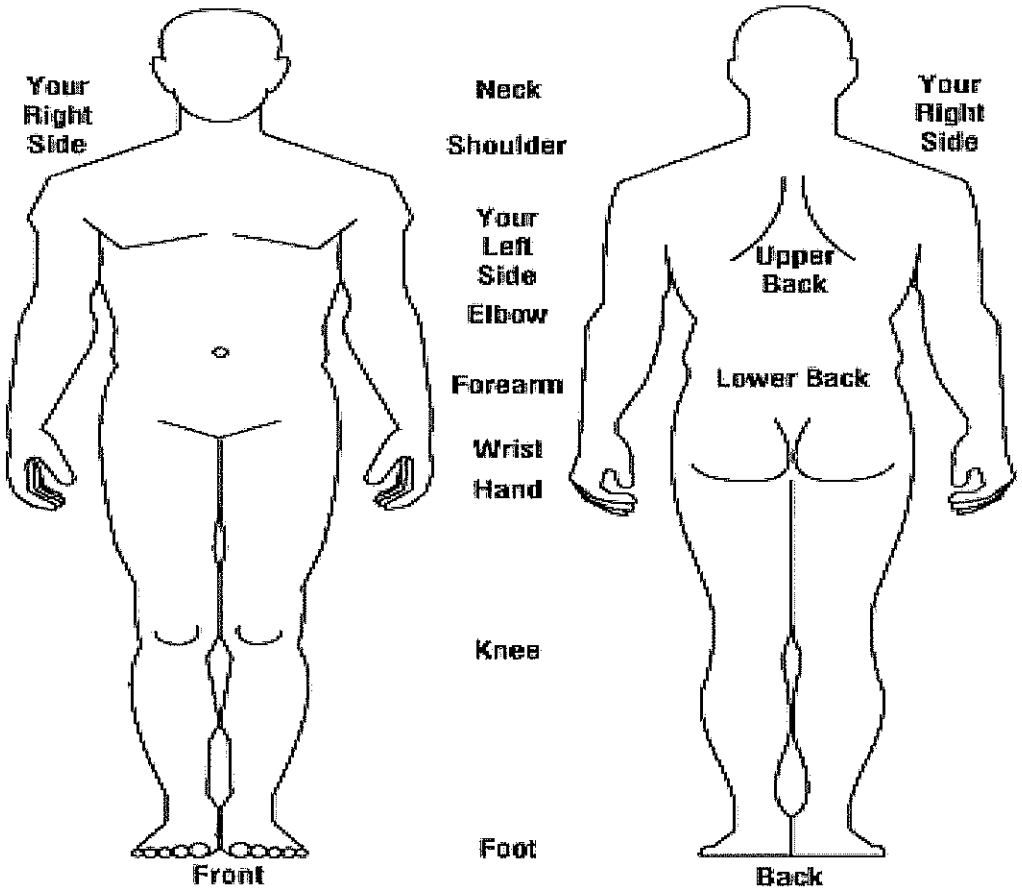
LOSS OF TASTE/SMELL _____ MENSTRUAL PROBLEMS _____

Have you been diagnosed with HIV/Aids, or Hepatitis? Yes or No
If yes, please tell us which type of hepatitis and year of diagnosis. _____

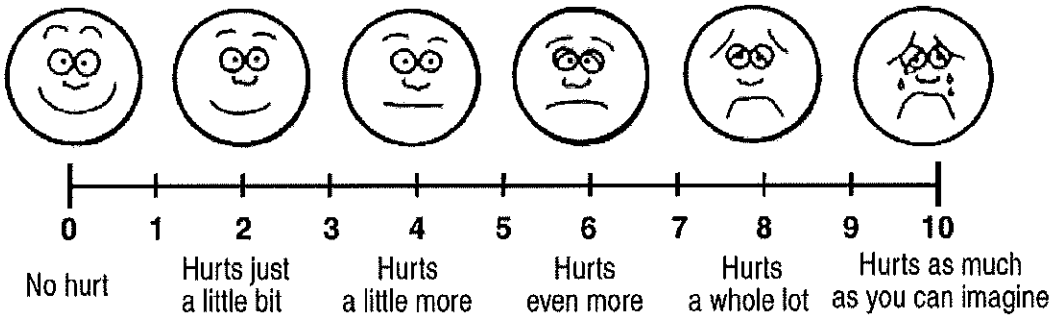
Date _____ **Signature** _____

PLEASE INDICATE THE LOCATION, TYPE AND INTENSITY OF YOUR PAIN USING THE SYMBOLS BELOW.

0000 PINS & NEEDLES XXXX-BURNING //// STABBING ** ACHING ++++ NUMBNESS**



On the 0-10 Pain Scale and the faces below, circle the number which best describes your pain.



Signature _____ Date_____