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 <u>not</u> living with you ____

Home # ______________________ Cell # ______________________

Please name the person who referred you here _________________________________

<u>*You will receive a statement once a month until your bill is paid in full*</u>

<u>We will not bill third party insurance</u> (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.

<u>INSURANCE AUTHORIZATION, ASSIGNMENT OF BENEFITS AND HIPAA NOTICICATION</u>

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: ___________

<u>Case History</u>

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 <u>any past injuries</u> 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**____

BODY SHEET

PATIENT INSTRUCTIONS: PLEASE INDICATE THE LOCATION, TYPE AND INTENSITY OF YOUR PAIN. USING SYMBOLS BELOW, SHOW WHICH AREA OF BODY THAT SYMBOLS EXIST.

000 pins & needles
xxx burning
/// stabbing
*** aching
— numbness

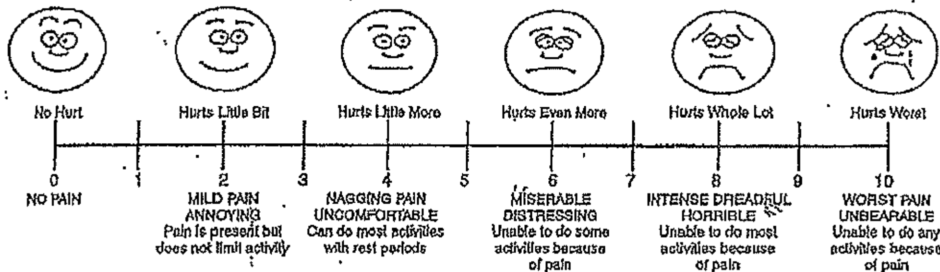
RIGHT LEFT

FRONT

LEFT RIGHT

BACK

2. On the 0 - 10 pain scale and the Faces scale below, circle the number which best describes your pain.



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SIGNATURE DATE