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AtlanticChiropractic.net



ATLANTIC CHIROPRACTIC ASSOCIATES, P.A.

Gentle, Effective Care for All Ages

Auto Accident - New Patient Intake

Title: Dr. Mr. Mrs. Ms. Miss (check one) **Gender:** Male Female **Date:** _____ / _____ / _____

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____ Preferred contact method : Cell Phone Home Phone Work Phone

Date of Birth: _____ / _____ / _____ Age: _____ Email: _____

Primary Doctor: _____ City: _____ State: _____

Race: (check one)

White Black/African American American Indian/Alaska Native Other _____ I choose not to specify

Ethnicity: (check one) Hispanic or Latino Not Hispanic or Latino I choose not to specify

Preferred Language: (check one)

English Spanish Other _____ I choose not to specify

Marital Status: Single Married Other _____ Is your spouse a patient in the clinic? Yes No

Spouse Data:

First Name: _____ Middle: _____ Last Name: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Patient Employer Data:

Employment Status: Employed FT/ PT Student FT/ PT Retired Homemaker Unemployed

Employer Name: _____

Address Line: _____ City: _____ State: _____

Job Title/Position: _____

Emergency Contact:

Contact Name: _____ Relationship: _____

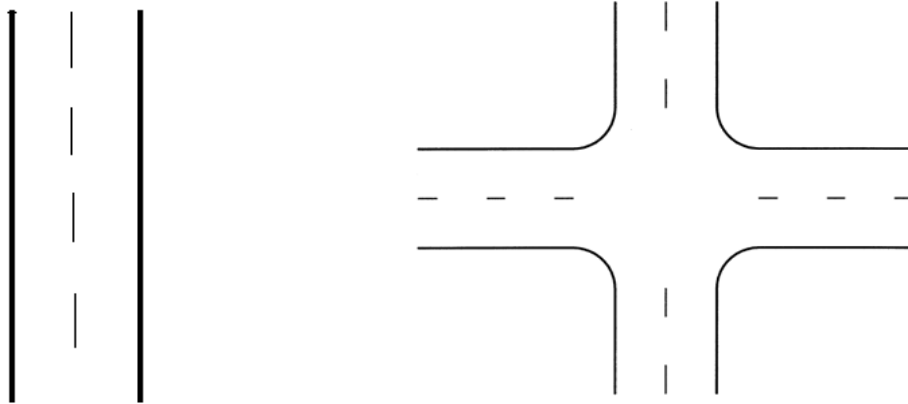
Phone: (_____) _____ - _____

Date of Injury/Accident: _____ Location(What state did it occur?) _____

Do you have an attorney? Yes No If yes, who? _____

IN YOUR OWN WORDS, PLEASE DESCRIBE HOW THE ACCIDENT OCCURED:

Please illustrate how the accident occurred using one of the diagrams:

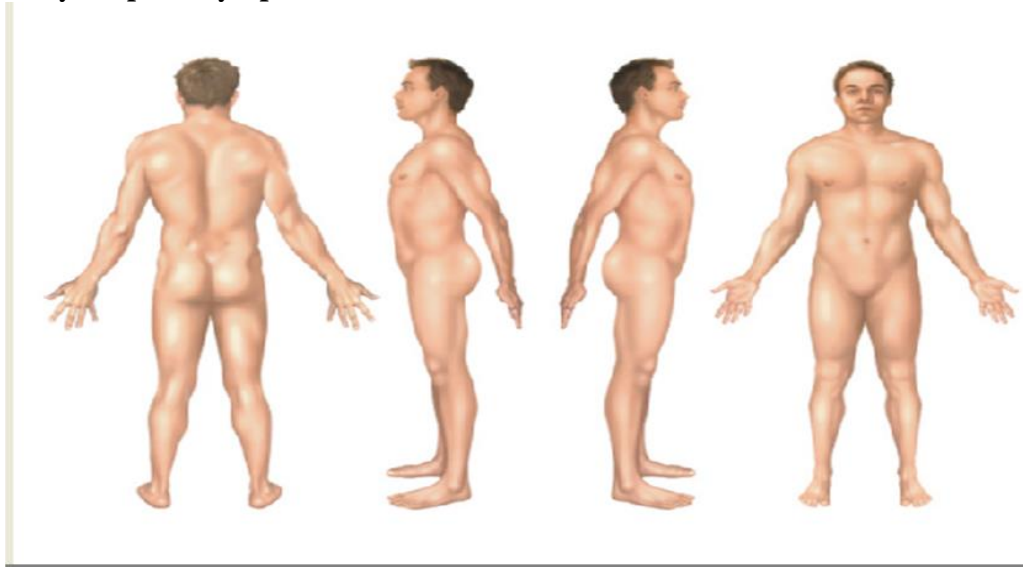


Point of Impact:

- | | | | |
|--------------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> Front | <input type="checkbox"/> Driver Front | <input type="checkbox"/> Passenger Front | <input type="checkbox"/> Rear |
| <input type="checkbox"/> Driver Side | <input type="checkbox"/> Passenger Side | <input type="checkbox"/> Passenger Rear | <input type="checkbox"/> Driver Rear |

Current Complaints:

Please mark where your pain/symptoms are:



Is your pain worse/better/the same in the morning/throughout the day/in the evening/at night ? Circle one from each group.

Patient Name: _____

Patient #: _____

Date: _____

Please grade your pain on a scale of 0-10:

Choose how frequent the pain is present:

[0= No Pain, 10= Extreme Pain]

Neck: 0 1 2 3 4 5 6 7 8 9 10

Seldom - Intermittent - Frequent - Constant

Upper/Mid Back: 0 1 2 3 4 5 6 7 8 9 10

Seldom - Intermittent - Frequent - Constant

Lower Back: 0 1 2 3 4 5 6 7 8 9 10

Seldom - Intermittent - Frequent - Constant

_____ 0 1 2 3 4 5 6 7 8 9 10

Seldom - Intermittent - Frequent - Constant

Area(s) of complaint:

1. _____ 3. _____

2. _____ 4. _____

Circle which ones describe your symptoms:

- dull • sharp • throbbing • burning • deep • aching
- tingling • stabbing • cramping • numbness • radiating • stiffness

Other symptoms: _____

Can you go to sleep without problems? Yes No

Do you awaken because of pain? Yes No

If yes, where is the pain that wakes you up? _____

Injury History General:

Was the crash on-the-job? Yes No

You were: Driver Front Seat Passenger L – M – R Rear Seat Passenger Pedestrian

Motorcycle Operator Motorcycle Passenger Other: _____

Vehicle Driven By: _____

Your Vehicle (year/make/model): _____

Other Vehicle (year/make/model): _____

If Driver:

How many hands were on the wheel? : One on wheel Two on wheel None

Were the brakes applied? Yes No

Your Estimated Speed at Moment of Crash:

Stopped

Slow (Example: Parking Lot/Stop Light)

Moderate (Example: Neighborhood)

Fast (Example: Highway)

Time of Day: Daylight Dawn Dusk Dark

Road Conditions: Dry Damp Wet Snow Ice Other: _____

What was the position of the top of your headrest? :

Middle of neck Middle of head None Even with the top of the head Even with the bottom of the head

If adjustable, did your headrest move due to the crash? Yes No Don't Remember

Did your seat move or change position? Yes: Base, Whole Seat, Seat Back No Don't Remember

Did your seat break? Yes No

Lap Belt: Wearing Not Wearing

Shoulder Belt: None Wearing Not Wearing Don't Know

Patient Name: _____

Patient #: _____ Date: _____

Did the airbag deploy? Yes No
If yes, were you struck by the air bag? Yes No What body part? _____
Did you strike anything in the vehicle? Yes No
If yes, what? Wheel Windshield Armrest Dashboard Side Window Airbag Side Door
Were you aware of impending crash? Yes No
Did you brace yourself for impact? Yes No
Direction of your head: Turned right Turned left Straight ahead Looking up Looking down
Did your head impact anything? Yes No Don't Know
Are you experiencing any? Mental Confusion Memory Loss Depression/Mood Swings Decrease Libido
 Distractibility Light Headedness

Other part of body injured? (Please list in order of severity.)
 1. _____ 3. _____
 2. _____ 4. _____

During the crash:
Did the vehicle strike any objects after crash? Yes No
If yes, please describe?

Were you dazed? Yes No
Did you lose consciousness? Yes No If yes, for how long? _____
Damage to your vehicle: Mild Moderate Extensive Totaled Unknown
Were police on the scene? Yes No If yes, report made? Yes No

After the crash:
Immediately after the accident, did you experience any of the following:
 Headaches Neck Pain Mid Back Pain Shoulder/Arm Pain
 Low Back Pain Hip/Leg Pain Dizziness Nausea
 Confusion Disorientation Other: _____

When did symptoms first appear? _____ (hours)
Where did you go after the crash? Work Hospital Home Other: _____

Emergency Department:
Hospital name: _____ **DATE:** _____

Mode of transportation: _____
Imaging / testing performed? Yes No
 If yes, please list type (X-ray, MRI, CT, Lab work, EMG, etc.) location and date taken:
 1. _____ DATE: _____
 2. _____ DATE: _____
 3. _____ DATE: _____

Results: _____

Medication prescribed: _____
Other treatments: _____
Follow-up instructions: _____

Self-assessed percent improvement as of today: (list for separate areas)
 Area _____ % Improved: _____
 Area _____ % Improved: _____
 Area _____ % Improved: _____

Patient Name: _____ **Date:** _____
Patient #: _____

Any prior history of current complaints? Yes No

If yes, please describe episodes with dates: _____

Prior treatment by a chiropractor for these? Yes No If yes, please list who and when:

1. _____
2. _____

Circle the activities that aggravate your condition:

- sitting
- standing
- walking
- bending
- stooping
- lifting
- sleeping
- sneezing
- coughing
- straining
- reaching
- twisting
- looking up
- looking down
- movement
- rest
- lying face down
- driving
- typing
- scooping
- house chores
- exercise
- lying face up
- stair stepping

Other aggravating factors: _____

Circle activities that relieve your condition:

- sitting
- standing
- lying
- knees bent up
- support
- no movement
- movement
- heat
- ice
- topical gel
- ibuprofen
- medication
- rest
- stretching/exercising
- adjustments

Other relieving factors: _____

General Information:

Handedness: L R Both

Tobacco Use: Current Every Day Smoker Sometimes Smoker Former Smoker Never been a Smoker

What is your level of interest in quitting smoking?

0 (No Interest) 1 2 3 4 5 6 7 8 9 10 (Very Interested)

Alcohol Use: None Social Moderate Heavy

Have you ever been disability rated? Yes No If yes, for what? _____

Treatment History:

Any prior Doctor seen for this condition? Yes No

1. Doctor Name: _____ Specialty: _____

Date seen: _____ Referred by: _____

Treatment type: _____

Currently treating? Yes No Did treatment help you? Yes No

Referred to another Provider? _____

Notes: _____

2. Doctor Name: _____ Specialty: _____

Date seen: _____ Referred by: _____

Treatment type: _____

Currently treating? Yes No Did treatment help you? Yes No

Referred to another Provider? _____

Notes: _____

Patient Name: _____

Patient #: _____ Date: _____

Current Medical History:

Current Health Problems (Heart Disease, Diabetes, High Blood Pressure, etc): None

Current Medications Taken:

Vitamins/Supplements None See Separate List

Are you currently pregnant? Yes No If so, what is your due date? _____

Have you had children? Yes No If so, how many children have you had? _____

List any known allergies you have to any medications: No known allergies

- 1. _____ 3. _____
- 2. _____ 4. _____

Has any doctor diagnosed you with High Blood Pressure? Yes No

Has any doctor diagnosed you with Diabetes presently? Yes No

If yes, what kind? Type 1 Type 2 If yes, was most recent hemoglobin A1c > 9.0%? Yes No Not Sure

If yes, other comments regarding Diabetes: _____

Past Medical History:

Injuries to Head, Neck, or Back, including Motor Vehicle Accidents or Work Injuries:

Surgeries (Include all, not just neck and back). List Date and Type: _____

Fractures (Include all, not just neck and back). List Date and Type: _____

Family History: please circle and check all that applies

Diabetes	Yes	No	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
Heart Disease	Yes	No	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
High Cholesterol	Yes	No	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
Hypertension	Yes	No	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
Osteoporosis	Yes	No	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
Cancer (specify): _____	Yes	No	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
Psychological Disorders	Yes	No	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
<input type="checkbox"/> No known Conditions								

Patient Signature: _____ Date: _____

To be performed by clinic staff: Height: _____ in Weight: _____ lbs BP: _____ / _____ Pulse: _____ bpm

Patient Name: _____

Patient #: _____ Date: _____

Authorization, Consent and Release

I consent and authorize the providers of Atlantic Chiropractic Associates, P.A. to examine and/or treat me / my child/legal dependent, if patient is a minor, today and during future office visits.

I authorize the release of any information, including the diagnosis and records of any treatment or examination rendered to me / my dependant during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay benefits directly to Atlantic Chiropractic Associates, P.A., for the services rendered. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all co-pays, deductibles, and any other subscriber liabilities at the time that services are rendered, as are allowable.

Signature of Patient or Parent/Guardian of Minor Patient

Date

Financial Policy

We are dedicated to providing you with the best possible care and service and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff. Unless other arrangements have been made in advance by either yourself or your health coverage carrier, **full payment is due at the time of service.** For your convenience, most credit cards are accepted.

Your Insurance

We have made prior arrangements with many insurers and health care plans. We will bill those plans with whom we have an agreement and will collect any required co-payment at the time of service. The co-payment will be collected when you arrive for your appointment. In the event that your health coverage plan determines a service to be "not covered," **you will be responsible for the complete charge.** In that event, we will bill you and payment is due upon receipt of that statement.

If you have insurance coverage with a plan with which we do not participate, **payment is expected at the time that services are rendered.** We will provide you with a receipt from our office for you to submit to your insurance carrier. Your insurance company should then send the payment directly to you.

Missed Appointments

In order to provide the best possible service and availability to all our patients, there may be a \$15.00 fee for any doctor appointment not canceled at least 24 hours in advance. Also, due to the scheduling of massage therapy, there may be a fee of 75% of our regular massage charges for appointments not canceled at least 24 hours in advance. Please call us as early as possible if you know you will need to reschedule your appointment. More than three (3) "no show" appointments without a valid reason may result in discharge from our practice.

I have read and understand the financial policy of the practice; and, I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Acknowledgment of Privacy Practices

Our practice is committed to protecting privacy and confidentiality. With my consent, Atlantic Chiropractic Associates, P.A., may use and disclose Protected Health Information (PHI) about me or my dependant to perform treatment, payment and healthcare operations (TPO). Please refer to Notice of Privacy Practices of Atlantic Chiropractic Associates, P.A. for a complete description of such uses and disclosures. I acknowledge that a copy of said Notice of Privacy Practices was offered to me.

Signature of Patient or Parent/Guardian of Minor Patient

Date

Patient Name: _____ 7
Patient #: _____ Date: _____

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Record Release

I, _____ / _____,
Patient Name Date of Birth

hereby request my records and/or imaging reports be released from:

Organization

Organization

Organization

and to be faxed/mailed/taken to Atlantic Chiropractic Associates, P.A.

Patient/Guardian _____ Date _____

Witness _____ Date _____

Patient Name: _____
Patient #: _____ Date: _____