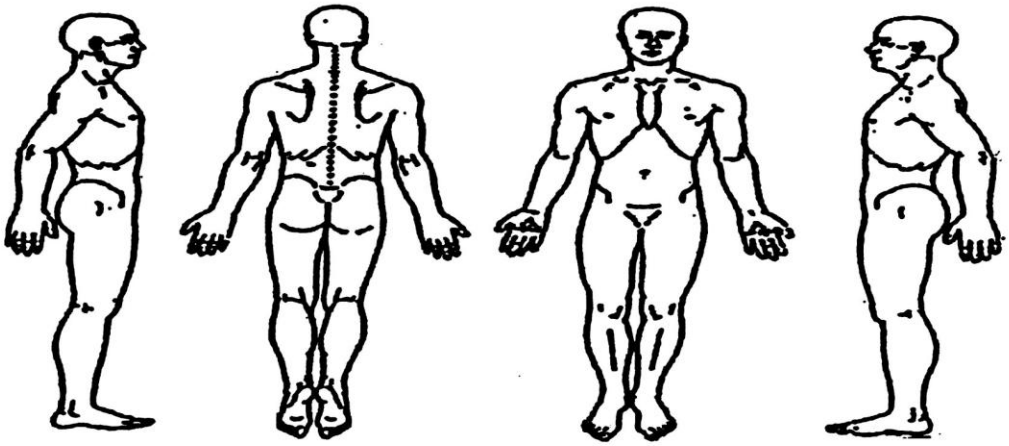
NEW PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

□ Insidious □ Posture □ Auto Accident □ Work Injury □ Fall □ Other _____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What makes your problem Worse? _____
Better? _____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ **Weight** _____ **Date of Birth** _____
Occupation _____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:_____				

20. List all prescription medications you are currently taking:
_____

21. List all of the vitamins and/or supplements you are currently taking:
_____

22. List all surgical procedures you have had:
_____

23. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?
_____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

26. Have you ever seen a chiropractor before? □ No □ Yes
if yes, how long ago? _____ How were the results? □ Great □ Good □ Average □ Poor

27. Have you had significant past trauma? □ No □ Yes

28. Anything else pertinent to your visit today?_____
Patient Signature_____ **Date:**_____

ABOUT THE ACCIDENT

1. What was the date of the accident?_____

2. What time did the accident occur?_____

3. How many vehicles were involved in the accident?_____

4. What was the estimated damage to the vehicle you were in? _____

5. What state did the accident occur in? _____

6. What city did the accident occur in? _____

7. What street or intersection were you on when the accident occurred?
_____

8. What direction were you traveling in? _____

9. What type of impact was the auto accident? _____

10. Did your vehicle hit anything after the accident? if yes, please describe
_____

11. Where were you sitting in the vehicle during the accident?
_____

12. Did you know the accident was coming?_____

13. What type of vehicle were you in? _____

14. What type of vehicle impacted yours? _____

15. At the time of the impact, how fast was your vehicle moving? _____

16. At the time of impact, how fast was the other vehicle moving? _____

17. During and after the crash what happened to your vehicle? (circle all that apply)
- kept going straight
- kept going straight hitting a car in front
- was hit by another vehicle
- spun around
- spun around and hit a stationary object
- hit a stationary object

18. Did you lose consciousness during the accident? -yes - no

19. How was your head positioned during the accident? _____

20. How was your torso positioned during the accident? _____

21. How were your hands positioned during the accident? _____

22. Did your head hit anything during the accident? -no - yes, please describe_____

23. Did your face hit anything during the accident? -no - yes, please describe_____

24. Did your shoulders hit anything during the accident? -no - yes, please describe_____

25. Did your neck hit anything during the accident? -no - yes, please describe_____

26. Did your chest hit anything during the accident? -no - yes, please describe_____

27. Did your hips hit anything during the accident? -no - yes, please describe_____

28. Did your knees hit anything during the accident? -no - yes, please describe_____

29. Did your feet hit anything during the accident? -no - yes, please describe_____

30. What kind of headrest was in your vehicle?
- movable fixed headrest
- nonmovable fixed headrest
- no headrest

31. Where was the headrest positioned on your head? _____

32. Did you have your seatbelt on during the accident? - yes -no

33. Did you slide out of your seatbelt during the accident? _____

34. What was damaged in your vehicle? (Circle all that apply)

- windshield	- rear bumper	- mirror
- steering wheel	- front bumper	- knee bolster
- dashboard	- trunk	- back right door
- seat frame	- front left door	- completely totaled
- side window	- front right door	
- rear window	- back left door	

35. Choose the items that dented inward
- floorboards - side door - dashboard

36. Choose the doors that would not open as a result of the accident
- front left - front right
- rear left - rear right

37. Did you go to the hospital? (If no, why and do not answer 38-43)
_____

38. How did get to the hospital? _____

39. What was the name of the hospital? _____

40. Were you hospitalized over night? _____

41. Circle what you were prescribed at the hospital
- pain medication - muscle relaxors - neck brace

42. Did you receive any stitches for any cuts at the hospital? _____

43. Were X-Rays, MRI OR Cat Scans taken at the hospital? If yes, which area was taken?
_____

Person Completing: _____ Signature: _____ Date: _____

LifeStyle Health & Fitness Center
5351 Neroly Road, Suite B
Oakley, California 94561
925-978-BACK

3rd PARTY AND ATTORNEY ACKNOWLEDGMENT AND UNDERSTANDING

(TO BE SIGNED BY PATIENT)

I hereby acknowledge that I am receiving (or about to receive) health care services from Dr. Rick Junnila or Dr. Brenda Ramos. I have been advised that the doctor providing services to me is willing to wait for payment for these services, providing that there be a reasonable chance that payment will be made either by insurance reimbursement or of the settlement of a liability claim or law suit.
I understand that if it is determined:

1, That there is no insurance company obligated to pay for these services, or if the insurance company involved refuses to acknowledge an assignment to the doctor or make other provisions for the protection of the doctor's charges, or

2. If a liability claim exists, and my current attorney or any new attorney I may retain at a later date refuses to agree to protect the interest of the doctor by signing a lien agreement, or

3. If I do not engage the services of an attorney,

I agree to pay for all services rendered to me on a current basis and any remaining balance owing on my account will be paid in full as soon as my liability claim is settled or within three months from the date of last treatment, which ever occurs first. On all accounts referred to collections or litigation all reasonable collection fees, attorney fees, court costs, and/or interest fees will be paid by patient/guarantor.

Furthermore I agree to make a "good faith" payment of $_____ on my account on or by the _____ day each month. I agree that I will continue to make these payments on my account regardless of treatment status and until my case has been settled and the balance is paid in full.

_____	_____
Patient's Name	Patient Date of Injury
_____	_____
Patient Signature	Date
_____	_____
Witness Signature	Date

AUTO ACCIDENT INSURANCE POLICY

*You may pay for your care by using one of these three methods:

1) MED-PAY

Your auto insurance Med-Pay coverage will pay for your care <u>in full, regardless of fault.</u> Med-Pay is a set amount of funds, usually $1,000, $5,000 or $10,000, which is put aside to pay your medical bills in case of an accident. You pay extra for this benefit, so use it. Your insurance rates are not affected by the cost of health expense, unless you were at fault. It is your responsibility to notify your claims office that you are being treated in this office and have them send any necessary paperwork directly to us. In the event your auto insurance DENIES that you hold insurance, REFUSES payment, DOE NOT HAVE Med-Pay Coverage, or you have EXHAUSTED your Med-Pay coverage, charges for services are due and payable.

2) GROUP HEALTH INSURANCE

Your group health insurance can be billed for your care. If you have an accident rider on your policy, it may be covered at 100%. You pay your deductible and co-payments as required and we will wait for the balance from the insurance company.

3) PATIENT PAYMENT

You can pay for your care as you go or we can arrange a convenient monthly payment plan for you. We will prepare billings for you to submit to your attorney, third party, etc.

****

You are considered a cash patient until all the required information is submitted to our billing office.

The only circumstance in which we will accept a lien is when all the above options are exhausted and you are making personal payments on your account. In this case, a lien may be accepted as a promise to pay the remaining portion of your bill.

We will bill your auto or health insurance and have you assign payment to us. In the event that your insurance company sends a check directly to you, be sure or bring it in, along with the attached stub, within three days. Otherwise, we may re-bill in error, which will delay future payments.

If the insurance company fails to pay a portion of your bill after 90 days, that balance will be due and payable by you.

****

Policyholder's Name: _____

Your Auto Insurance Company's Name:_____

Policy# _____ Claim #:_____

Med-Pay Coverage?:(yes)_____ (no)_____ Amount: $_____

Adjustor's Name:_____ Phone#:_____

Claims Office Address:_____

LifeStyle Family Chiropractic Health and Fitness Center

New Patient Information
Welcome to our office! Please complete all questions.

Name: _____ Date: _____

Address: _____

City/State/Zip_____

Home Phone _____ Cell Phone _____

Work Phone _____

E-Mail

Date of Birth _____ Sex: M F CA Drivers License #: _____

Employer _____ Occupation _____

Marital Status: S M W D

Current Health Complaints

1) _____ 2) _____
3) _____ 4) _____
5) _____ 6) _____

Have you ever seen a chiropractor before? ( ) Y ( ) N

How did you hear about our office? _____

Please Select One

( ) Yes I would like a copy of the 6 page HIPAA form to Sign and Read (Medical Privacy - National Standards to Protect the Privacy of Personal Health Information).

( ) No I understand my HIPAA privacy rights and with my signature below I acknowledge this:

Patient Signature: _____