

## Spine Worx Chiropractic & Decompression Confidential Patient Case History

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell \_\_\_\_\_  
Phone \_\_\_\_\_ Occupation \_\_\_\_\_  
Email \_\_\_\_\_  
Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Spouse's Name \_\_\_\_\_ # of  
Children \_\_\_\_\_ How Did You Hear About Our  
Office? \_\_\_\_\_  
Emergency Contact: Name/Relationship \_\_\_\_\_ Phone \_\_\_\_\_

### Detailed Auto Accident Description

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 (driver, front passenger, etc.)?  
\_\_\_\_\_
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 overnight? \_\_\_\_\_

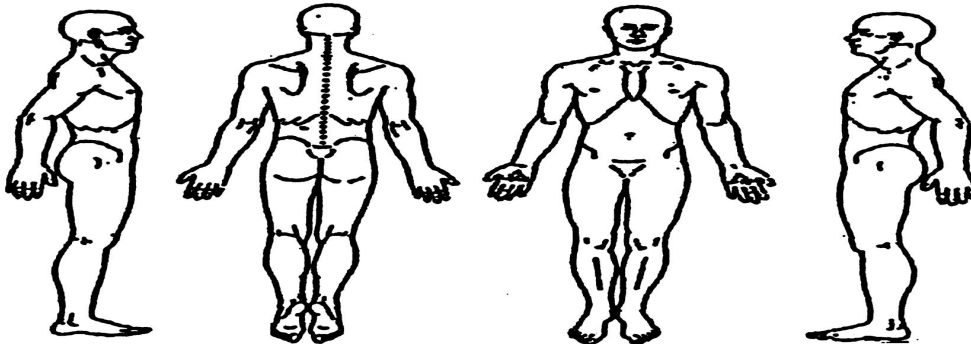
41. Circle what you were prescribed at the hospital  
- pain medication      - muscle relaxers      - neck brace

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

43. Were x rays taken at the hospital? If yes, which area was taken?  
\_\_\_\_\_

1. Please describe what brought you in today (What hurts):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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       Radiates/Travels: \_\_\_\_\_  
 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

Name of physician \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_

10. How long have you had this problem? \_\_\_\_\_

11. How do you think your problem began?

\_\_\_\_\_

12. Do you consider this problem to be severe?

- Yes                       Yes, at times                       No

13. What makes your problem worse?

\_\_\_\_\_

14. What makes your problem better?

\_\_\_\_\_

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

\_\_\_\_\_

16. How long has it been since you really felt good?

\_\_\_\_\_

17. List previous diagnoses and treatment you have received for present condition \_\_\_\_\_

18. What is your: Height \_\_\_\_\_ Weight \_\_\_\_\_

19. What type of exercise do you do?

- Strenuous                       Moderate                       Light                       None

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

21. List all prescription medications you are currently taking:

\_\_\_\_\_

22. List all of the over-the-counter medications/ supplements you are currently taking:

\_\_\_\_\_

23. List all surgical procedures you have had:

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24. Have you ever been hospitalized?  No  Yes

if yes, why \_\_\_\_\_

25. Please list any significant past trauma, slips, falls, broken bones, and/or accidents you've had from childhood to present: Date:

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26. What activities do you do at work?

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Sit:           | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand:         | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone:  | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |

27. What activities do you do outside of work?

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28. Please list main goals of treatment:

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29. Anything else pertinent to your visit today? \_\_\_\_\_

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## Patient Informed Consent

I, \_\_\_\_\_, the undersigned, consent to care at this clinic. I understand that I have the opportunity to discuss with the doctor and/or with other office personnel, the nature and purpose of chiropractic adjustments, massage, decompression, and wellness related care. I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient above, for whom I am legally responsible) by the doctor of chiropractic and support team at Spine Worx Chiropractic & Decompression.

I also understand that as is with all healthcare treatments, results are not guaranteed, there is no promise to cure and that there are some risks. Risks include, but are not limited to; aggravating and/or temporary increase in symptoms, muscle spasms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor's judgment, based upon the facts then known, is in my best interests. I further understand that chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Reviewing Doctor: \_\_\_\_\_ Date: \_\_\_\_\_

# Spine Worx Chiropractic & Decompression

## Financial Agreement

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE. THERE IS A \$25.00 FEE FOR NO CALL/ NO SHOW MISSED APPOINTMENTS.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Spine Worx Chiropractic & Decompression all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action against my insurers and/or employee health care plan.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## HIPPA Privacy Notice

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_