Vehicle Accident Patient Application

WELCOME, and THANK YOU for applying as a patient in our clinic. We are a very unique team specializing in research-based spinal and postural rehabilitation. These methods have enabled our patients to achieve their optimal health; even when many other systems have failed.

Because of this specialized approach, we may not accept you as a patient until we perform the necessary tests that will give us insight into the cause of your condition, allowing us to develop an optimal rehab program for you, and are confident we can help you. If we accept you as a patient, we will make your health a priority and expect you will as well.

Patient Information

Full Name:________________________________ Date: _____ / _____ / _____ Gender: M F

Home Address:________________________________ Cell Phone: ( )____________

City, State, Zip:________________________________ Home Phone: ( )____________

Email Address:________________________________ Work Phone: ( )____________

Birth Date: _____ / _____ / _____ Age:____________ Social Security #: ______ - _____ - _______

Occupation:____________________ Employer's Name:____________________

Marital Status: S M D W Number of children: ____________

Spouse's Name:____________________ Occupation:____________________

Spouse's Employer:________________________________

List two persons way may contact in case of an emergency

Name:____________________ Phone #: ( )__________ Relationship:____________

Name:____________________ Phone #: ( )__________ Relationship:____________

Health & Lifestyle

Do you smoke? ☐ No Packs per day:__________ Years: ____________

Do you drink alcohol? ☐ No ☐ Social ☐ Light ☐ Moderate ☐ Heavy

Do you drink coffee? ☐ No Cups per day: ____________________

Do you exercise? ☐ No ☐ Occasionally ☐ Regularly Times per week:____________

If yes, what type of exercise? ________________________________

Please list hobbies/leisure activities:________________________________

Work is mostly: ☐ Office/Clerical ☐ Homemaker ☐ Light Labor ☐ Moderate Labor ☐ Heavy Labor

Do you take any supplements (i.e. vitamins, minerals, herbs)? ☐ None ☐ Yes, please list:

____

Purpose for this Visit - **MAIN** Area - **ONE area only**

Main area for this visit (describe): ______________________

When did these symptoms begin? ______________________

Is this related to an accident or specific injury? ☐ No ☐ Yes

If yes, explain: ______________________

Are the symptoms: ☐ Constant ☐ Intermittent ☐ Activity-related

Are the symptoms: ☐ Improving ☐ Getting Worse ☐ Remaining the same

What aggravates your symptoms? ______________________

Is there anything that relieves the symptoms? ☐ No ☐ Yes: ______________________

Have you experienced these symptoms before? ☐ No ☐ Yes, when? ______________________

Have you already been treated for this? ☐ No ☐ Yes, who did you see? ______________________

What treatment was performed, and how did you respond? ______________________

____

What is your pain **RIGHT NOW**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is your **TYPICAL** or **AVERAGE** pain? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is your pain level **AT ITS BEST**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is your pain level **AT ITS WORST**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

Purpose for this Visit - **SECONDARY** Area - **any other areas**

Other areas for this visit (describe): ______________________

When did these symptoms begin? ______________________

Is this related to an accident or specific injury? ☐ No ☐ Yes

If yes, explain: ______________________

Are the symptoms: ☐ Constant ☐ Intermittent ☐ Activity-related

Are the symptoms: ☐ Improving ☐ Getting Worse ☐ Remaining the same

What aggravates your symptoms? ______________________

Is there anything that relieves the symptoms? ☐ No ☐ Yes: ______________________

Have you experienced these symptoms before? ☐ No ☐ Yes, when? ______________________

Have you already been treated for this? ☐ No ☐ Yes, who did you see? ______________________

What treatment was performed, and how did you respond? ______________________

____

What is your pain **RIGHT NOW**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is your **TYPICAL** or **AVERAGE** pain? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

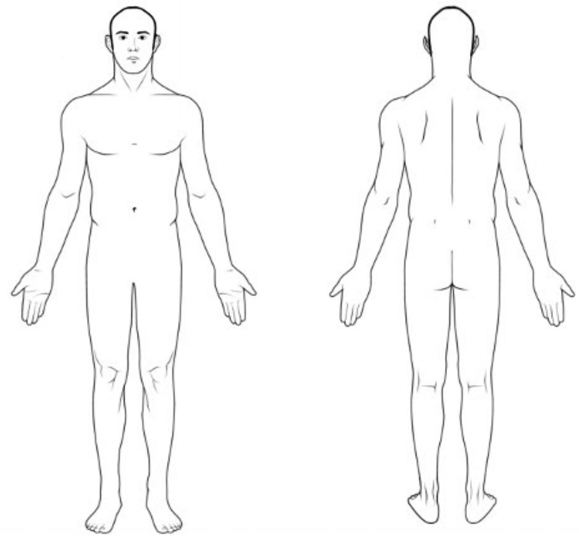
What is your pain level **AT ITS BEST**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is your pain level **AT ITS WORST**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

Symptoms Chart

Please **shade** the areas of symptoms and **label** the diagram using the following abbreviations.

A Ache
B Burning
S Sharp / stabbing
N Numbness
T Tingling
O Other



Activities of Daily Life

Please identify how your current condition(s) is affecting your ability to carry out routine activities.

Choose one for each of the activities below: • Activity has no effect, • You can do activity, but it is painful, • You are limited in the activity, and it is painful, • You are unable to perform the activity.

ACTIVITIES:	EFFECTS:			
Carrying	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Exercise	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Going Up & Down Stairs	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading/Concentrating	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Yard Work	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform

Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL areas of the spine. These distortions are reflected in abnormal posture. Misalignment of the individual vertebrae or distortion of the normal spinal curves may result in many health conditions. Please answer the following questions accurately so we may determine the full extent of your condition.

Please indicate next to all conditions you've experienced: (N) = Now (P) = Past (B) = Both

Cervical Spine (Neck)

☐ None

___Neck pain
___Pain in shoulders/arms/hands
___Numbness/tingling in arms/hands
___Coldness in hands
___Weakness in grip
___Headaches
___Dizziness
___Visual disturbances
___Hearing disturbances
___Jaw pain/clicking
___Thyroid conditions
___Low energy/fatigue
___Recurrent colds/Flu
___Sinus infections
___Allergies/Hay fever

Please explain:____

Thoracic Spine (Upper Back)

☐ None

___Upper back pain
___Pain on deep inspiration/expiration
___Shortness of breath
___Asthma/wheezing
___Recurrent lung infections/bronchitis
___Heart attack/angina
___Heart palpitations
___Tachycardia (rapid heartbeat)
___Heart murmurs

Thoracic Spine (Mid Back)

☐ None

___Mid back pain
___Pain in chest/ribs
___Indigestion/heartburn
___Reflux
___Nausea/upset stomach
___Ulcers/gastritis
___Diabetes
___Tired/irritable after eating or when not have eaten for a while
___High/low blood sugar

Please explain:____

Lumbar Spine (Lower Back)

☐ None

___Low back pain
___Pain in hips/legs/feet
___Numbness/tingling in legs/feet
___Coldness in legs/feet
___Weakness/injuries in hips/knees/ankles
___Muscle cramps in legs/feet
___Constipation/diarrhea
___Irritable bowel syndrome
___Frequent/difficulty in urinating
___Recurrent bladder infections
___Sexual dysfunction
___Menstrual irregularities/ cramping

Please explain:____

Other Health Information

Current primary care provider: ____________________

Do you have allergies? ☐ No ☐ Yes: ____________________

Do you take any over-the-counter medication? ☐ No ☐ Yes, list how much/often:

____

Do you take any prescription medication? ☐ No ☐ Yes, see below

Please list any prescription medications:

Medication	How much/often	Starting Date

Please list any surgeries (include type of surgery and date performed) ☐ None

Surgery	Date

Health History

Are you aware of any poor posture habits? ☐ No ☐ Yes

If yes, explain: ____________________

Do you have or have you had any of the following? Please check the boxes below for the conditions that apply.

☐ None

☐ Cancer	☐ ADHD/ADD	☐ Hernia	☐ Shingles
☐ Heart disease	☐ Depression	☐ Lung disease	☐ Lyme disease
☐ High blood pressure	☐ Migraine headaches	☐ Liver disease	☐ Autoimmune disorder
☐ High cholesterol	☐ Diabetes	☐ Kidney disease	☐ Osteoporosis
☐ Circulatory problems	☐ Low blood sugar levels	☐ Thyroid problems	☐ Arthritis
☐ Stroke	☐ Gallbladder problems	☐ Fibromyalgia	☐ Broken bones/fractures
☐ Neurological problems	☐ Tonsillectomy	☐ Eczema/psoriasis	☐ Scoliosis
☐ Epilepsy/seizures	☐ Appendectomy		

Please explain: ____________________

____

Please list any health conditions not mentioned: ____________________

Family Health History

Is there any history of spinal problems in your family? ☐ No ☐ Yes

If yes, explain: ______________________________

Is there a family history of: ☐ None

	Cancer	Heart Disease	Diabetes	Arthritis	Other
Father	☐	☐	☐	☐	______
Mother	☐	☐	☐	☐	______
Sister	☐	☐	☐	☐	______
Brother	☐	☐	☐	☐	______

Experience with Chiropractic

Have you seen a chiropractor before? ☐ No ☐ Yes Who?______________________________

For what?______________________________

How long were you treated?____________________ Last treatment: _____ / _____ / _____

How did you respond?______________________________

Did your previous chiropractor take 'before' and 'after' x-rays? ☐ No ☐ Yes

Did he/she recommend a specific course of treatment? ☐ No ☐ Yes

Did he/she recommend a home health care program? ☐ No ☐ Yes

If yes, what?______________________________

____

HIPAA Privacy Notice

By signing below, I acknowledge that I have received and reviewed the HIPAA privacy notice and all of my questions have been answered to my satisfaction in a language I can understand.

Print Name	Signature	Date

If patient is under the age of 18:

Signature of Legal Guardian	Relationship to Patient	Date

Informed Consent for Chiropractic Care

Please read this entire document prior to signing it. Please ask questions before you sign if there is anything that is unclear.

I hereby request and consent to the performance of conservative noninvasive treatment to the joints and soft tissues from Green Chiropractic, P.C. I understand that the procedures may consist of manipulations/
adjustments involving movement of the joints and soft tissues. Physical therapy, traction and exercises may also be used.

Spinal and extremity manipulations/adjustments are considered to be one of the safest, most effective forms of therapy for musculoskeletal problems and are exceedingly safe when applied properly. However, I understand there are some risks to care including, but not limited to: soreness/bruising, dizziness, fracture/joint injury, sprain and stroke. Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare (reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning). I do not expect the doctor to anticipate and explain all of the risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure.

I understand that it is my responsibility to inform my doctor should I have a concern regarding privacy of the area in which I receive my care. I understand a portion of my treatment may be performed in an open treatment area, though I may request care in a private room.

Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me. These include rest, home applications of therapy, prescriptions or over-the-counter medications, exercises and possible surgery.

<u>Medications:</u> Medications can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence and may have to be continued indefinitely. Some medications may involve serious risks.

<u>Rest/Exercise:</u> It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

<u>Surgery:</u> Surgery may be necessary of joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia and prolonged recovery.

<u>Non-treatment:</u> I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of care now and in the future. I am free to withdraw my consent and discontinue care at any time.

Patient's Signature	Date

If patient is under the age of 18:

Signature of Legal Guardian	Relationship to Patient	Date

Green Chiropractic Financial Policies

Green Chiropractic will do everything we can to bring out the best in you and your health, but we wish to make it very clear that your health is your responsibility. Our financial options are listed below. Please select the appropriate one and sign your acknowledgement of our policy below.

_____Cash

Payment is due at the time services are rendered. We accept cash, check, debit, Visa, Mastercard, Discover and AmEx cards.

_____Insurance Plan

Many insurance policies provide coverage for chiropractic care. Benefits will vary from policy to policy and cannot be guaranteed until an Explanation of Benefits (EOB) is received. Payment on your first visit is required to establish your account. We will contact your primary carrier to obtain benefits and process your claims. Any remaining balance is your responsibility.

_____Medicare

Payment is due at the time services are rendered. Exams, x-rays and supplements are a non-covered service with Medicare. We will submit your charges to Medicare. We are considered non-assignment; therefore, any EOB's and/or payments made by Medicare will be sent directly to you.

_____Medicaid

We accept all Medicaid plans. Visit limits and co-pays may apply.

_____Personal Injury

Please provide Green Chiropractic with any accident reports and attorney information. We will send your claims to your auto insurance carrier if you have a MedPay policy. Any remaining balance is your responsibility.

_____Worker's Comp

Prior approval is typically required before any services are rendered. Obtain and provide Green Chiropractic with the name of your employer's work comp insurance carrier and claim number.

I clearly understand that all insurance coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience to me. The chiropractic office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

____ ________________

Patient's Signature Date

Injury History

Your name: ______________________________

Date of Injury: _____ / _____ / _____

City / Intersection closest to accident: ______________________________

Was the accident on the job? ☐ Yes ☐ No

Were you the: ☐ Driver ☐ Front seat passenger ☐ Rear seat passenger
☐ Motorcycle operator ☐ Motorcycle passenger ☐ Other

Your vehicle was struck from: ☐ Rear ☐ Front ☐ Driver side ☐ Passenger side

Did your vehicle collide with another object? ☐ Other vehicle ☐ Structure ☐ None

Was there a second collision? ☐ No ☐ Yes, describe: ______________________________

Vehicle You Were In

Driver's name: ______________________________ Number of people in vehicle: __________

Your vehicle:

Year:__________ Make:____________________ Model: ____________________

At the time of the impact, was your vehicle stopped? ☐ Yes ☐ No, estimated speed: _______ mph

If moving, your vehicle was: ☐ Slowing down ☐ Steady speed ☐ Gaining speed

If you were the driver, was your foot on the brake? ☐ Yes ☐ No

Other Vehicle

Year: __________ Make:____________________ Model: ____________________

Was the other vehicle moving at the time of the collision? ☐ No ☐ Yes, estimated speed:_____ mph

Site

Direction you were headed: ☐ North ☐ South ☐ East ☐ West ☐ N/A

Name of street: ______________________________

Direction other vehicle was headed: ☐ North ☐ South ☐ East ☐ West ☐ N/A

Name of street: ______________________________

Time of day: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark

Road condition: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice ☐ Other: __________

Occupant Factors

Head restraint: ☐ None ☐ Non-adjustable ☐ Adjustable

If adjustable, was it: ☐ Low position ☐ Mid position ☐ High position

Was it altered by the accident? ☐ Yes ☐ No

The top of the head restraint was: ☐ Below the top of your ear ☐ Above the top of your ear

The head restraint was: ☐ More than 4 inches from the back of your head

☐ Less than 4 inches from the back of your head

Seat:

Was the seat back adjustment altered by the accident? ☐ Yes ☐ No

Was the seat broken by the accident? ☐ Yes ☐ No

Seatbelt:

Lap belt: ☐ Wearing ☐ Not wearing

Shoulder belt: ☐ Wearing ☐ Not wearing

Did you receive any bruises from the shoulder/lap belt? ☐ Yes ☐ No

Did you receive any bruises from the air bags? ☐ Yes ☐ No

Body position at time of collision: ☐ Straight forward ☐ Turned left ☐ Turned right

☐ Leaning forward

Head position at time of collision: ☐ Looking forward ☐ Turned left ☐ Turned right

☐ Looking up _____ ☐ Looking down _____

Hands were: ☐ One on wheel - ☐ Left side ☐ Right side

☐ Both on wheel ☐ N/A

Just prior to the collision, were you: ☐ Aware of approaching crash ☐ Unaware of approaching crash

During the Crash

Did any part of your body strike any parts of the vehicle? ☐ No ☐ Yes, please describe:

____

Did you receive any cuts or bruises? ☐ No ☐ Yes, please describe: ____________________

Wearing hat or sunglasses? ☐ No ☐ Yes

If yes, were they still on after impact? ☐ No ☐ Yes

Did you lose consciousness? ☐ No ☐ Yes, how long? ____________________

Estimated property damage to your vehicle: $______________

Estimated property damage to other vehicle(s): $______________

Did the police come? ☐ No ☐ Yes, was a police report filed? ☐ No ☐ Yes

Following the Crash

Did you go to a hospital or medical office? ☐ No ☐ Yes

If so, how did you get there? ☐ Ambulance ☐ Someone else drove ☐ Drove yourself

When did you go? ☐ Same day ☐ Next day ☐ 2 days or more afterwards

Name of hospital or medical office: ______________________

Were any x-rays taken? ☐ No ☐ Yes, what area?

What were the results? ______________________

Treatment given: ☐ Cervical collar ☐ Medication ☐ Other: ______________

Recommended follow-up: ______________________

Treatment

Have you seen any doctors, chiropractors, or physical therapists for this injury? ☐ No ☐ Yes, see below

	Name	Date seen	Treatment given	Did treatment help?
1.				☐ Yes ☐ No
2.				☐ Yes ☐ No
3.				☐ Yes ☐ No

What studies have been done for this injury?

☐ None	When	Where
☐ X-ray		
☐ CT scan		
☐ MRI scan		
☐ Bone scan		
☐ Other		

Employment

Have you lost time from work as a result of this injury? ☐ No ☐ Yes

If yes, dates lost: ______________________

Has your occupation changed since this injury? ☐ No ☐ Yes

If yes, what was your occupation at the time of the injury? ______________

If yes, did your occupation change because of this injury? ☐ No ☐ Yes

Explain: ______________________

Have you noticed any activity restrictions as a result of this injury? ☐ No ☐ Yes

If yes, explain: ______________________

Prior Health Status

Did you have any physical complaints before this injury? ☐ No ☐ Yes

If yes, describe in detail: ______________________