LOUISIANA CHIROPRACTIC
415 Court Street Port Allen, LA 70767
225-336-1920, (f) 225-343-8399

MOTOR VEHICLE ACCIDENT HISTORY FORM

Patient: _____ Age: _____ Birth Date: _____

Are you or have you missed time from work? ☐Yes ☐ No Type of Work: ☐ Office ☐ Clerical ☐ Light ☐ Moderate ☐ Heavy Labor

Describe the type of work performed: _____

Were you on-the-job when the accident occurred? ☐ Yes ☐ No

Were you the: ☐ Driver ☐ Front Seat Passenger ☐ Rear Seat Passenger ☐ Other _____

Vehicle was driven by: _____

Did your vehicle strike another vehicle? ☐ Yes ☐ No Did another vehicle strike your vehicle? ☐ Yes ☐ No

Were you struck from: ☐ Behind ☐ Front ☐ Driver's side ☐ Passenger's side ☐ other _____

Were traffic citations issued? To whom? ☐ You ☐ Driver of your vehicle ☐ Driver of other vehicle ☐ None

Were police at the scene? ☐ Yes ☐ No If yes, was a report made? ☐ Yes ☐ No Did accident occur on ☐ public or ☐ private property

Your vehicle was heading: ☐ North ☐ South ☐ East ☐ West on _____ (Street/highway)

The other car heading: ☐ North ☐ South ☐ East ☐ West on _____ (Street/highway)

Your Vehicle (Year, Make, Model): _____

Your speed at the moment of accident: ☐ Full Stop ☐ Slowing ☐ Accelerating ☐ Legal Limit

The other Vehicle (Year, Make, Model) _____

Time of day: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark Road conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice ☐ Other _____

Head restraints: ☐ None ☐ Integral Type ☐ Adjustable: ☐ Up ☐ Down ☐ Don't know

If adjustable, was the position altered by the accident? ☐ Yes ☐ No

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

Type of Restraints: _____

Did air bag deploy? ☐ Yes ☐ No If Yes, were you struck by airbag? ☐ Yes ☐ No Were you burned? ☐ Yes ☐ No

Body position: _____ Head position: ☐ Forward ☐ Left _____° ☐ Right _____° ☐ Up _____° ☐ Down _____°

Position of Hands: ☐ One on steering wheel ☐ Two on steering wheel ☐ N/A Were brakes applied at impact? ☐ Yes ☐ No

Patient signature _____

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Patient: _____

Accident Description: (How did the accident happen?) _____

_____

_____

Were you aware of impending crash?: ☐ Yes ☐ No

Did your body hit any part of your vehicle? ☐ Yes ☐ No If yes, describe _____

Did anything inside the vehicle strike you? ☐ Yes ☐ No If yes, describe _____

Did your vehicle hit any other object after the crash? ☐ Yes ☐ No If yes, describe _____

Were you wearing a hat or eye or sunglasses? ☐Yes ☐ No If yes, were they still on after crash? ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No If yes, for how long _____

Estimated damage to your vehicle: ☐ None ☐ Minimal ☐ Moderate ☐ Major

Estimated damage to other vehicle: ☐ None ☐ Minimal ☐ Moderate ☐ Major

Since the crash, tell me **ALL** symptoms or injuries you have experienced and specifically when each began: _____

_____

_____

Where did you go after accident? ☐ Hospital ☐ Urgent Care ☐ Family Provider ☐ Home ☐ Work ☐ Other_____

Emergency Room Treatment:

Were you seen in the ER: ☐ Yes ☐ No Which hospital: _____ Were taken by ambulance? ☐ Yes ☐ No

Date seen if not taken by ambulance _____

Was treatment given? ☐ Yes ☐ No If yes, X-rays: ☐ Yes ☐ If yes, which body parts x-rayed _____

Results of X-rays: _____ Lab work ☐ Yes ☐ No Results: _____

Cervical collar ☐Yes ☐No Ice ☐ Yes ☐ No Medication: ☐ Yes ☐ No If yes, name of Rx: _____

Other treatment: _____ Follow-up Instructions: _____ ☐ None

Work restriction ☐ Yes ☐ No If yes, describe_____

Other Treatment Since Crash #1:

Doctor: _____ Specialty: _____ Date first seen: _____

Referred by: _____ Treatment type: _____ Treatment frequency: _____

Treatment duration: _____ Currently treating? ☐ Yes ☐ No

Work restriction ☐ Yes ☐ No If yes, describe_____

Special tests: _____ Referred to: _____

Did treatment help? ☐ Yes ☐ No Comments: _____

Patient signature _____

LOUISIANA CHIROPRACTIC NEW PATIENT INTAKE

Name:_____ Today's Date:_____

Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: ( )_____ Cell: ( )_____ Work: ( )_____

Email Address: _____ Male: ____ Female: ____

Social Security Number: _____ Birth Date: _____ Age: _____

Occupation: _____

Employer Name and Address: _____

Single: _____ Married: _____ Spouse's Name: _____

Have you seen a Chiropractor before? Yes No If yes, when?_____

Whom may we thank for referring you to our office? _____

YOUR HEALTH HISTORY

Please ☑ check all conditions you have ever had, even if they do not seem related to your current problems.

☐ Cancer	☐ Dizziness	☐ Headaches	☐ Fatigue
☐ Diabetes	☐ Loss of balance	☐ Pins & Needles in Arms	☐ Sleeping Problems
☐ Current Infections	☐ Rheumatoid Arthritis	☐ Pins & Needles in Legs	☐ Constipation
☐ History of Stroke	☐ Currently Pregnant	☐ Numbness in fingers	☐ Heartburn
☐ Pacemaker	☐ Unstable Joints	☐ Numbness in toes	☐ Allergies
☐ Epidural Hematoma	☐ Herniated Disc	☐ Cold Hands	☐ Menstrual Pain
☐ Anti-coagulant Therapy	☐ Ringing in ears	☐ Cold Feet	☐ Surgery (list below)
☐ Osteoporosis	☐ Shingles	☐ Fainting	
☐ Abdominal Aneurysm	☐ Seizures	☐ Depression	

_____

Do you smoke? Yes/No. If yes: How many years/packs per day? _____(packs/day)_____(years smoked)

List any medications you are taking: _____

_____N/A or None.

Do you have any medically-diagnosed conditions?:_____

_____N/A or None.

Does anyone in your family have any medically-diagnosed conditions (If so, whom)?:_____

_____N/A or None.

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Dr. Initials: _____

CURRENT HEALTH CONDITION

NAME: _____ DATE: _____

What is your chief health complaint? _____

When did this condition begin? Most Recently _____ Initially _____

How often do you get the symptoms? _____

Why do you think you have these symptoms? _____

What makes it feel better? (Heat, ice, stretching, etc.) _____

What makes it feel worse? (Movement, sitting, standing, etc.) _____

Condition Frequency: ☐Constant☐Frequent☐Intermittent ☐Off/On☐Occasional
Symptom Change: ☐Worsening☐Same ☐Improving ☐ Unsure

How do these symptoms affect your daily life? (Can't workout, sleep, sit, work, do house/yard work, etc.)
_____

Rate the Symptom at worst: 0 1 2 3 4 5 6 7 8 9 10
(Least) to (Worst)

What kind of symptoms do you have? **(Circle all that apply)**
Sharp Stabbing Dull Ache Burning Tingling Throbbing Radiating

Do the symptoms travel/radiate into your arms, legs or head? _____
When does it hurt the most?_____ least?_____
Describe how it feels as the day goes on: _____
_____
Other Doctors Seen for This Condition: ☐ YES ☐ NO If yes, whom and when?: _____
_____

If you have any other symptoms/complaints please list them: _____
_____
Have you ever been involved in any motor vehicle accidents or other injury (even if minor)? If so when/explain?_____
_____

How many hours a day do you sit (Desk, computer or phone)?_____

What are your top three health goals?
1. _____
2. _____
3. _____

Signature: _____ Dr. Initials: _____

LOUISIANA CHIROPRACTIC LLC
Assignment of Benefits

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and consideration of treatment rendered or to be rendered, assigns to Dr. Dane Owes, D.C., of Louisiana Chiropractic, the following rights, powers, and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney, or insurance adjuster, for the purpose of processing my claim for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my/our favor against any insurance company for the terms of policy, including the exclusive, irrevocable rights to receive payment for such services, make demand in my/our name(s) for payment and prosecute and receive penalties, in accordance to insurance and state statutes. I/We, as a patient(s) and /or responsible party, further agree to cooperate, provide information as needed, to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by Dr. Dane Owens, D.C. of Louisiana Chiropractic, within 60 days following your receipt of such bill services, extend such bills are payable under the terms of my/our policy for benefits, less any amount which I/we owe which are not payable under the terms of the policy. This amount also conforms to state insurance codes that provide for attorney fees, penalties, court costs and interest from judgment, upon violation.

STATUTE OF LIMITATIONS: I/We waive the right to claim for services rendered or to be rendered by Dr. Dane Owens, D.C., of Louisiana Chiropractic, in addition to reasonable costs, including attorney fees and court costs, if incurred.

LIMITED POWER OF ATTORNEY: I/We hereby grant Dr. Dane Owens, D.C., of Louisiana Chiropractic, the power to endorse my/our name(s) upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by Dr. Dane Owens, D.C. I/We agree that any insurance payment representing an amount in excess of the charges of treatment rendered will be credited to my/our account or forwarded to my/our address upon written request to Dr. Dane Owens, D.C., of Louisiana Chiropractic.

TERMINATION OF CARE WAIVER: I/We hereby acknowledge and understand that if I/we do not keep appointments as recommended to me/us by Dr. Dane Owens, D.C., of Louisiana Chiropractic, he/they have full and complete right to terminate responsibility for my/our care and relinquish disability granted to me/us within a reasonable period of time. If, during the course of my/our care, my/our insurance company requires me/us to take an examination from any other doctor, I/we will notify Dr. Dane Owens, D.C., of Louisiana Chiropractic, immediately. I/We understand that failure to do so may jeopardize my case.

NOTICE OF HIPAA PRIVACY PRACTICES: I have been given the opportunity to review this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document. Initial:_____

********** A photocopy of this instrument shall serve as original**********

SIGNATURE OF PATIENT AND/OR RESPONSIBLE PARTIES:

NAME :_____ DATE: _____

NAME: _____ DATE: _____

LOUISIANA CHIROPRACTIC LLC

751 COURT STREET
PORT ALLEN LA 70767
PHONE: (225) 336-1920 FAX: (225) 343-8399

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: the state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer diagnosis or treat any disease. We only offer to diagnosis either vertebral subluxations or neuro-musculoskeletal conditions. However, during the course of chiropractic spinal examination we encounter non-chiropractic our unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advise regarding treatment prescribed by others OUR ONLY PRACITCE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

Therefore, I accept chiropractic care on this basis.

_____ _____
(signature) **(date)**

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle _____.

_____ _____
(signature) **(date)**