Confidential Patient Information – Auto Injury

Patient Contact Information:

Last Name:_____ **First:**_____ **Initial:**____ **Home Phone:**_____
Nick Name:_____ **Cell Phone:**_____
Address:_____ **Work Phone:**_____ Ext:____
City:_____ State:_____ Zip:_____ **Email:**_____
Birth Date:_____ **Gender:** (□Male □Female) **Marital Status:** (□S □M □W □D □Partnered)
Occupation:_____ **Employer:**_____

Whom may we thank for referring you? (□Insurance □Phone Book □Web Search □Drive By □Other:_____)

Partner/Parent/Guardian/Emergency Contact:

Name:_____ **Relationship**_____ **Cell Phone:**_____

Address:_____ **Home Phone:**_____ **Work Phone:**_____

Patient Symptoms:

Please explain the primary reason for your appointment, specific areas of pain, and discomfort:_____

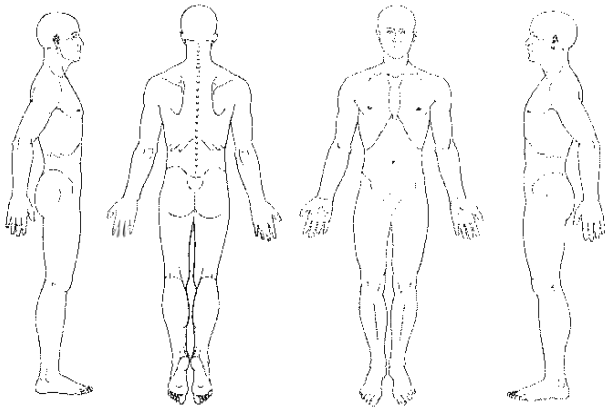
Date of Injury:_____

My condition has been getting: □Gradually Worse □Rapidly Worse □Staying About the Same □Getting Better
Activities or movements painful to perform: □Sitting □Standing □Walking □Bending □Lying Down □Other:_____
Interferes with your: □Work □Sleep □Daily Routine □Recreation

I would describe my pain as: (circle as many as apply)

CONSTANT	FREQUENT	INTERMITTENT	OCCASIONAL
VERY SEVERE	SEVERE	MODERATE	DULL
STABBING	SHARP	ACHING	MILD
BURNING	TINGLING	THROBBING	NUMBNESS
SHOOTING	STIFFNESS	SWELLING	OTHER:_____

PLEASE INDICATE AREAS OF DISCOMFORT



What is your pain on a scale from 1(least) to 10 (severe)_____
How often do you have this pain?_____
Is it constant or does it come and go? _____
I have tried the following solutions for this problem:

New to Chiropractic: (□No □Yes) **Previous Chiropractic Care:** (□No □Yes)

Dr:_____ When?_____
For treatment of:_____
Was there a specific treatment that was successful?_____
Present Family Doctor:_____ **Phone Number:**_____

Other Doctors consulted for these health problems:

Dr. Name:_____ When:_____
Diagnosis:_____ Treatment:_____
How long did you see the Doctor?_____ How frequently?_____
Results:_____

YOUR VEHICLE AND ACCIDENT DETAILS

Make/Model/Year of your Vehicle:_____ **Were you the:** □ Driver □Passenger □Front □Rear

Make/Model/Year of the other Vehicle:_____

Please briefly describe the accident:_____

_____

What direction was the impact from? □ Front □ Rear □ Left □ Right □

Other:_____

Placement of hands on the steering wheel? □ Both hands □ Only right hand □ Only Left Hand

Were you: □ Surprised by the impact **OR** □ Braced for Impact

□ NO □ YES Were you using a safety belt? □Lap □Shoulder **The head rest was in the:** □ Low □ Mid-position □ High

□ NO □ YES Equipped with air bags? Did they inflate? □ NO □ YES **Was your car:** □Moving OR □Stationary

□ NO □ YES Did your car hit another vehicle? What speed were you traveling? _____

□ NO □ YES Were you hit by more than one car?

□ NO □ YES Did your car impact a structure? If yes please explain: _____

□ NO □ YES Did part of your body strike anything in the vehicle? If yes please explain:_____

□ NO □ YES Was your foot on the brake?

POLICE: **Was a report filed?** □ NO

□ YES **Traffic violation issued to:** _____

Officer Name: _____**Phone Number:** _____

Case #: _____

PATIENT CONDITION

□ NO □ YES Were you knocked unconscious? If yes, how long? _____

□ NO □ YES Did you feel pain immediately after the accident? If No, when did the pain begin? _____

□ NO □ YES Were you examined by a Medical Professional for this condition? _____

□ NO □ YES Were you hospitalized? If yes, where and when: _____

□ NO □ YES Diagnostic Imaging: □ X-ray □ Cat Scan □ MRI □ Ultrasound □ Other: _____

□ NO □ YES Have you lost any days of work? Date from: _____to: _____

□ NO □ YES Have you had previous complaints in the injured area? **How long ago?** _____

Exercise/or Work Level:		Exercise:	Lifestyle:	Family:
□ None	□ Sitting	□ Swimming	□ Smoking (Pack/Day:_____)	# Infant(s) under 2:_____
□ Daily	□ Standing	□ Biking	□ Coffee/Caffeine (Cups/Day:_____)	# Children: _____
□ Moderate	□ Light lifting to 20#	□ Jog/Run	□ Alcohol intake (Drinks/Week:_____)	# Care giver for:_____
□ Heavy	□ Heavy lifting +20#	□ Yoga	□ High Stress (Reason:)_____	
□ Other:_____			□ Other:_____	

Current Medication:	Adverse Side Effects or Allergies:

Injuries/Surgery:	Date/Year:	Description:
Falls/Accidents:	□No □Yes	
Head Injuries:	□No □Yes	
Broken Bones/Dislocations:	□No □Yes	
Previous Hospitalizations:	□No □Yes	
Surgeries:	□Head □Neck/Throat □Back □Abdominal □Chest / Heart / Lungs □Other:_____	

Financial Responsibility and Insurance Information:

Auto Insurance Company:_____ **Insurance Phone:** _____

Claim Number: _____ **Policy Number:** _____

Claim Adjuster:_____ **Phone #:** _____

Attorney Name (If Applicable):_____ **Phone #:** _____

OTHER DRIVER & INSURANCE INFORMATION

Last Name:_____ **First:**_____ **Initial:**____ **Phone:**_____

Insurance Company:_____ **Insurance Phone:** _____

Claim Number: _____ **Policy Number:** _____

Signature of Fact, Receipt of Notice Privacy Policies, Acknowledgement of Insurance Assignment and Release:

To the best of my knowledge and ability, I have provided true and complete information. I understand that I am financially responsible for all charges whether or not paid by insurance. By signing below I authorize the doctor, his designated staff and/or insurance company to release any information required for processing insurance claims. I assign any and all appropriate insurance benefits be paid directly to Dr. Bahm/Pine Lake Chiropractic Clinic, P.S. for services rendered.

I have received and reviewed, or had the opportunity to review, and understand and agree to the HIPPA *Notice of Privacy Practices of Pine Lake Chiropractic Clinic, P.S.,* which describes the Practice's policies and procedure regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

X_____ _____

Signature of Patient

_____ _____

Printed Name **Date**

Consent for Treatment of Minors or Dependants:

By my signature below, I hereby authorized Pine Lake Chiropractic Clinic, P.S. and their designated staff to administer care to my child or dependent as they deem necessary.

X_____ _____

Signature of Parent or Guardian **Date** **Relationship to Patient**