Active Lifestyle Clinic | KEEPING YOU ACTIVE FOR LIFE

Auto Accident Case History

1. PERSONAL INFORMATION

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail Address:_____ Fax #_____ Cell Phone:_____

How do you prefer to be contacted by us? Text or Email? If Text: Which carrier do you use? _____

Birth Date:_____ Marital Status: ❒ Married ❒ Single ❒ Widowed ❒ Divorced

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse Name:_____ # children?_____ Names and Ages children: _____

_____

Emergency Contact:_____ Phone: _____

How were you referred to our office?_____

Family Medical Doctor:_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?_____

AUTHORIZATION AND RELEASE: I authorize payment of automobile insurance benefits directly to the chiropractor or naturopathic office. I authorize the doctor(s) to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this Active Lifestyle Clinic 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. The following person(s) have my permission to receive my personal health information:

_____

_____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

2. HISTORY OF PRESENT AND PAST INJURIES:

Main Complaint #1: Purpose of this appointment:_____

Date accident happened:_____

Have you ever had the same or a similar condition? ❒ Yes ❒ No If yes, when and describe:_____

_____

Is your condition getting better, worse, same? _____ On a scale from 0-10, what # do you rate pain? _____

How often do you experience your condition? ❒ Constant ❒ Frequent ❒ Intermittent ❒ Occasional

What makes your symptoms worse? _____ What makes symptoms better? _____

Do you feel worse in the: ❒ morning ❒ afternoon ❒ during the day ❒ evening ❒ night

Describe your pain: ❒ achy ❒ burning ❒ dull ❒ sharp ❒ stiff ❒ throbbing ❒ spasm

Complaint #2: Describe:_____

Date symptoms appeared or accident happened:_____

Have you ever had the same or a similar condition? ❒ Yes ❒ No If yes, when and describe:_____

_____

Is your condition getting better, worse, same? _____ On a scale from 0-10, what # do you rate pain? _____

How often do you experience your condition? ❒ Constant ❒ Frequent ❒ Intermittent ❒ Occasional

What makes your symptoms worse? _____ What makes symptoms better? _____

Do you feel worse in the: ❒ morning ❒ afternoon ❒ during the day ❒ evening ❒ night

Describe your pain: ❒ achy ❒ burning ❒ dull ❒ sharp ❒ stiff ❒ throbbing ❒ spasm

Do you have a history of stroke or hypertension?_____Women: Are you pregnant? _____

Other health information:

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? _____

_____

Have you been treated for any health condition by a physician in the last year? ❒ Yes ❒ No

If yes, describe:_____

What medications or drugs are you taking?_____

Do you have any allergies to any medications? ❒ Yes ❒ No

If yes, describe:_____

Do you have any other allergies (seasonal/food,etc)? ❒ Yes ❒ No _____

Do you have any Congenital Condition? ☐ Yes ☐ No If YES, Describe _____

3. NATURE OF ACCIDENT:

1. Date of Accident: _____ Time of Day: _____

2. Were you: ❒ Driver ❒ Passenger ❒ Front Seat ❒ Back Seat Right ❒ Back Seat Left ❒ Middle

3. Number of people in your vehicle: _____ Other vehicle: _____

4. What direction were you headed? ❒ North ❒ East ❒ South ❒ West
   On (name of the street) _____

5. What direction was the other vehicle headed? ❒ North ❒ East ❒ South ❒ West
   On (name of the street) _____

6. Were you wearing your seatbelt/harness? ❒Yes ❒ No
   Did the seat belt and shoulder strap engage? ❒ Yes ❒ No
   Did you hit the ❒ dash ❒ steering wheel ❒ window

7. If driving, did you have both hands on the steering wheel at the time of impact? ❒ Yes ❒ No
   If passenger, did your hands brace yourself? ❒ Yes ❒ No
8. Did you have your feet or foot braced on the floor or dash board ❒ Yes ❒ No Brake? ❒ Yes ❒ No

9. Did the air bag engage? ❒ Yes ❒ No

10. Did you know you were going to be hit? ❒ Yes ❒ No

11. What part of your car was hit?
    ❒ Back end- off to either side? ❒ Left ❒ Center ❒ Right
    ❒ Front end – off to either side? ❒ Left ❒ Center ❒ Right

12. Approximately how many miles/hour were you driving at the time of impact? _____ MPH
    Approximately how many miles/hour was the other car(s) driving the time of impact? _____MPH

13. Which way was your head turned at the time of impact? _____
    Were you leaning forward at the time of impact? ❒ Yes ❒ No
    Did your glasses end up in the back seat or floor? ❒ yes ❒ No
    Was your body turned at the time of impact? ❒ Yes ❒ No

14. Did your car spin or roll over? ❒ Yes ❒ No Explain: _____

15. Were you knocked unconscious? ❒ Yes ❒ No If yes, for how long? _____

16. Were you pushed into…. ❒ Another car ❒ Tree ❒ Something else: _____

17. Was there any damage done to your or any one else's vehicle? ❒ Yes ❒ No Please explain: _____
    _____

18. What size/kind of car were you in? _____ The other car? _____

19. Did you hit your head in the accident? ❒ Yes ❒ No
    What did you hit? ❒ Headrest ❒ Window ❒ Other _____
    If you hit your head, what part of the head? _____

20. What part of the body did you notice pain in? _____

21. When did you notice the pain? Please describe how you felt.
    a. DURING the accident: _____
    b. IMMEIDATLEY AFTER the accident: _____
    c. LATER THAT DAY: _____
    d. THE NEXT DAY: _____

22. In your own words, please describe the accident: _____

_____

_____

_____

23. What are your present complaints and symptoms? _____

_____

24. Where were you taken after the accident? _____

25. Have you been treated by another doctor since the accident? ❒ Yes ❒ No
If yes, please list the doctor's name and address: _____

_____

What type of treatment did you receive? _____

_____

26. Since the injury occurred, are your symptoms: ❒ Improving ❒ Getting Worse ❒ Same

27. Check ALL symptoms you have noticed since the accident:

❒ Headache	❒ Irritability	❒ Numbness in Toes	❒ Face Flushed	❒ Chest Pain
❒ Neck Pain	❒Shortness of breath	❒ Ringing in ears	❒ Neck Stiff	❒ Dizziness
❒ Fatigue	❒ Loss of balance	❒ Sleeping Problems	❒ Heavy Head	❒ Depression
❒ Fainting	❒ Back Pain	❒ Light Sensitivity	❒ Loss of Smell	❒ Nervousness
❒ Loss Memory	❒ Loss of Taste	❒ Pins/Needles in arms	❒ Tension	❒ Ears Ring
❒ Diarrhea	❒ Feet/Hands Cold	❒ Pins/Needles in legs	❒Stomach Upset	❒ Constipation

28. Have you lost time from work as a result of the accident? ❒ Yes ❒ No
If yes, please complete the following questions:
    a. Last day worked: _____
    b. Type of employment: _____
    c. Are you being compensated for time lost from work? ❒ Yes ❒ No
    If yes, please state type of compensation you are receiving. _____

29. Did you notice any activity restrictions as a result of this injury? ❒ Yes ❒ No
If yes, please describe in detail: _____

_____

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____ *Date* _____

Signature of Patient/Legal Guardian _____

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INFORMED CONSENT

PATIENT NAME _____

Chiropractic Care:
I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as " Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process..

There are certain, rare complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, strains and dislocations, costovertebral strains and separation. Extremely rare complications include, but are not limited to stroke or fracture. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

Massage:
I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any discomfort, I will immediately inform the therapist so that the pressure can be adjusted to my level of comfort. I agree to keep the therapist updated to any changes in my health and understand that there shall be no liability on the therapist's part if I fail to do so.

Naturopathic Care:
I understand that all injection treatments are accompanied by possible risks. Risks include bruising, temporary increase in pain, inflammation, infection, allergic reaction, numbness, weakness or paralysis, spinal headache, lung puncture or death as a result of, or in relation to the injections.

Injections may include nerve blocks, Intravenous therapies, trigger blocks, intramuscular injections, scar therapy, joint/tendon/ligament injections, or prolotherapy.

I understand that insurance reimbursement for injections varies and that prolotherapy may be considered investigational or experimental by some carriers or Medicare.

I am aware of all of the above mentioned complications for each therapy I may receive, and in order to minimize their occurrence I will take precautions. I have been given the opportunity to discuss the nature and purpose of all treatments in this office, alternative methods of treatment, risks and complications associated with them. I acknowledge that all my questions have been answered to my satisfaction and that I have been further told that any additional questions I may have will be answered.

If my child is a minor, I have given consent for him/her to receive the necessary care in this clinic according to this consent.

DATE _____

_____
Printed Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)