SPINAL CHECK FOUNDATION

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Date _____ **PATIENT INFORMATION** Case#_____

Doctor_____

PLEASE FILL IN THE APPROPRIATE SPACES. (All information you give is confidential)

Patient Name (Last)_____ (First)_____

Street Address_____ Apt #_____

City _____ State_____ ZIP_____ Email_____

Phone (Home)_____ (Work)_____ (Cell)_____

Sex ☐ M ☐ F Date of Birth ____/____/____ Social Security #____-____-____

Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced Spouses Name _____ # of children_____

Employed ☐ Full Time ☐ Part Time ☐ Retired ☐Not Employed ☐ Student

Occupation _____Patient's Employer's Name _____

Address _____

City _____ State _____ ZIP _____ Phone _____

How did you hear about our office? _____ Referred by _____

Emergency Contact: _____ Phone: _____ Relationship:_____

INSURANCE INFORMATION (commercial Insurance and Medicare only)

Primary Insurance Company _____ Type ☐ Group ☐ Private

ID/Policy # _____ Group Name _____Group Number_____

Insured's Name _____ Insured's Date of Birth ____/____/____

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other Insured's Employer_____

Secondary Insurance Company _____Type ☐ Group ☐ Private

ID/Policy # _____ Group Name _____Group Number_____

Insured's Name _____ Insured's Date of Birth ____/____/____

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other Insured's Employer_____

AUTOMOBILE ACCIDENT / WORKER'S COMPENSATION ONLY

Insurance Company _____Policy #_____ Claim # _____

Adjuster's Name_____Address _____MedPay? ☐ Yes ☐ No

City _____ State _____ ZIP _____ Phone _____

Attorney's Name _____Contact Name _____Phone_____

Address _____

RELEASE AND ASSIGMENT: I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

Patient Signature _____Date _____

Date _____ **PATIENT HISTORY** Case#_____

Doctor_____

PLEASE FILL IN THE APPROPRIATE SPACES. (All information you give is confidential)

MAJOR COMPLAINT: _____

How long have you had this condition? _____

Date of Onset?_____

Have you lost workdays? ☐ Yes ☐ No If Yes, how many?_____

Have you had the same condition before ? ☐ Yes ☐ No If yes, when?_____

Was the injury accident related ? ☐ Auto Accident ☐ Work Accident If yes, when?_____

Previous Chiropractic Care? ☐ Yes ☐ No Chiropractor's Name_____

What was the reason for your initial visit?_____

What spinal maintenance programs were you given to follow to maximize the future stability of your spine?_____

Did you follow it? _____ If not, why? _____

_____

What surgeries have you had _____

List drugs you now take (prescription and non-prescription)_____

_____

_____

Name other doctors you have seen for this condition: _____

What are your health goals?_____

How do you expect to achieve these goals? _____

_____

Please mark if you have had any of these symptoms in the last 12 months:

☐ Fractured bones
☐ Auto accidents
_____0-1 years ago
_____2-5 years ago
_____6 years or more
☐ Other accidents, falls
☐ Arthritis
☐ Diabetes
☐ Convulsions, epilepsy
☐ Skin problems
☐ Cancer
☐ Frequent colds, flu
☐ Depressed
☐ Irritable
☐ Anemia
☐ Allergy, Sinus
☐ Under stress
☐ Eating disorders
☐ Trouble sleeping
☐ Trouble concentrating
☐ Learning disability
☐ Mood Changes

☐ Neck pain or Stiffness R L
☐ Numbness, tingling, pain in arms, hands, fingers R L
☐ Jaw pain or click (TMJ) R L
☐ Difficulty in excessive
Standing, sitting, riding
Bending, lifting, twisting
☐ Shoulder pain
☐ Dizziness
☐ Ringing in ears R L
☐ Hearing Loss
☐ Blurred or double vision
☐ Upper back pain, stiffness
☐ Mid back pain, stiffness
☐ Lower back pain, stiffness
☐ Pain with cough, sneeze
☐ Hip pain R L
☐ Headaches
☐ ADD/ADHD

☐ Numbness, tingling, pain in buttocks, legs, feet, toes R L
☐ Foot Trouble R L
☐ Heart Problems
☐ Stroke
☐ High/Low Blood Pressure
☐ Chest Pain, Asthma
☐ Liver trouble
☐ Gall bladder problems
☐ Digestive problems
☐ Ulcers
☐ Hemorrhoids
☐ Prostate Problems
☐ Impotence
☐ Kidney trouble
☐ Menstrual Problems, PMS
☐ Pregnant (now)
☐ Bedwetting
☐ Ear infections
☐ Varicose Veins
☐ AIDS, HIV

Accident History Questionnaire

PERSONAL INJURY PATIENT HISTORY

Date _____ Claim # _____

Name _____ Social Security # _____

Date of Birth _____ Age _____ Sex ❑ M ❑ F

Circle one: Married Single

Address _____ E-Mail _____

City _____ State _____ Zip _____

Employed by _____

Home Phone _____ Cell Phone _____ Work Phone _____

Referred to this office by _____

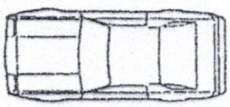
Name and number of emergency contact _____

Relationship to patient _____

1. Date of Accident: _____ 2. Time: _____AM/PM
3. Driver of Car: _____
4. Where were you seated? _____
5. Who owns the car? _____
6. Year & Model of your car. _____

   Year & Model of the other car. _____
7. What was the approximate damage done to your car? $ _____
8. Visibility at time of accident: ❑ poor ❑ fair ❑ good ❑ other: _____
9. Road conditions at time of accident: ❑ icy ❑ rainy ❑ wet ❑ clear ❑ dark

   ❑ other (describe): _____
10. Where was your car struck?

FRONT  REAR

In your own words, please describe accident: _____

_____

_____

11. Type of Accident: ❑ Head-on collision ❑ Broad-side collision ❑ Front impact

    ❑ Rear-end car in front ❑ Rear impact ❑ Non-collision
12. At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car:

    _____
13. Did you see the accident coming? ❑ yes ❑ no
14. Did you brace for impact? ❑ yes ❑ no
15. Were seatbelts worn? ❑ yes ❑ no
16. Were shoulder harnesses worn? ❑ yes ❑ no
17. Does your car have headrests? ❑ yes ❑ no
18. If yes, what was the position of those headrests compared to your head before the accident?

    ❑ Top of headrest even with **bottom** of head

    ❑ Top of headrest even with **top** of head

    ❑ Top of headrest even with **middle** of neck

19. Was your car braking? ❑ yes ❑ no
20. Was your car moving at the time of the accident? ❑ yes ❑ no
21. If yes, how fast would you estimate you were going? _____ mph
22. How fast would you estimate the other car was going? _____ mph
23. Head/Body position at the time of impact:
    - ❑ Head turned left/right
    - ❑ Head looking back
    - ❑ Head straight forward
    - ❑ Body straight in sitting position
    - ❑ Body rotated right/left
    - ❑ Other:
24. As a result of the accident you were: ❑ Rendered unconscious ❑ In shock ❑ Dazed, circumstances vague ❑ Other:
25. How was the shoulder harness adjusted? ❑ Loose ❑ Snug
26. Were you wearing a hat or glasses? ❑ yes ❑ no
27. Could you move all parts of your body? ❑ yes ❑ no
28. If no, what parts couldn't you move and why?

    _____
29. Were you able to get out of the car and walk unaided? ❑ Yes ❑ No
30. If no,why not? _____
31. Did you get any bleeding cuts? ❑ Yes ❑ No If yes, where? _____
32. Did you get any bruises? ❑ Yes ❑ No If yes, where? _____
33. Please describe how you felt:
    Immediately after the accident: _____
    Later that day: _____
    The next day: _____
34. Check symptoms apparent since the accident:

❑ Headache	❑ Neck pain/Stiffness	❑ Mid back pain
❑ Eyes Light Sensitive	❑ Pain Behind Eyes	❑ Dizziness
❑ Fainting	❑ Sleeping problems	❑ Numbness in fingers
❑ Numbness in toes	❑ Loss of smell	❑ Loss of taste
❑ Loss of memory	❑ Fatigue	❑ Breath shortness
❑ Irritability	❑ Depression	❑ Ringing/Buzzing
❑ Loss of balance	❑ Tension	❑ Cold hands
❑ Cold feet	❑ Diarrhea	❑ Constipation
❑ Chest pain	❑ Nervousness	❑ Cold Sweats
❑ Anxious	❑ Facial Pain	❑ Clicking or Popping Jaw
❑ Low Back Pain	❑ Other _____	

    _____
35. Occupation: _____
36. Employer: _____
37. Have you missed time from work: ❑ yes ❑ no
38. If yes, full time off work: _____ to _____
39. If yes, part time off work: _____ to _____
40. Did you seek medical help immediately after the accident? ❑ yes ❑ no
41. If yes, how did you get there? ❑ Ambulance ❑ Police ❑ Someone else drove me ❑ Drove own car ❑ Other: _____
42. Doctor #1: Name: _____
43. First Visit Date: _____

44. Were you examined? ❑ yes ❑ no
45. Were X-rays taken? ❑ yes ❑ no
46. Did you receive treatment? ❑ yes ❑ no ❑ Medications ❑ Braces ❑ Collars
47. If yes, what kind of treatment did you receive? _____
48. What benefits did you receive from the treatment? _____
49. Date of last treatment: _____
50. Doctor #2: Name: _____
51. First Visit Date: _____
52. Were you examined? ❑ yes ❑ no
53. Were X-rays taken? ❑ yes ❑ no
54. Did you receive treatment? ❑ yes ❑ no
55. If yes, what kind of treatment did you receive? _____
56. What benefits did you receive from the treatment? _____
57. Date of last treatment: _____
58. Do you have an attorney on this claim? ❑ yes ❑ no
59. If yes, who? _____
Address _____
City _____ State _____ Zip _____ Phone _____

Past Medical History: Place an (X) if it applies and describe.

❑ None related to current complaints ❑ Hospital or operation
❑ Auto Accident ❑ Work Accident ❑ Illness ❑ Other
Describe _____

Family History: Place an (X) if any family member has suffered from:

❑ Tuberculosis	❑ Kidney Disease	❑ Spinal Disorder
❑ Mental Illness	❑ Epilepsy	❑ Diabetes
❑ Gout	❑ Allergy	❑ Arthritis
❑ Hypertension	❑ Cancer	❑ Migraines
	❑ Heart Attack	❑ Other, list: _____

Are you pregnant? ❑ yes ❑ no
Medications, describe _____
Disease, describe _____
Other, describe _____

Spinal Check Foundation LLC

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are more often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Spinal Check Foundation LLC have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and/or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ___/___/___ _____Witness Initials

Patient or Authorized person's Signature Date

Regarding: X-rays/Imaging Studies

Females ONLY- please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

- ☐ The first day of my last menstrual cycle was on ____-____-____ Date
- ☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child,, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ___/___/___ _____ Witness Initials

Patient or Authorized person's Printed

_____

Patient or Authorized person's Signature