Hope Health & Wellness Ctr

2001 MLK Jr Dr. Sw #309 Atlanta, GA 30310
Office: (404) 564-6497
www.wellconnectedchiros.com

PERSONAL INJURY / ACCIDENT MEDICAL HISTORY INTAKE FORM

(Mark a ✓ on each that applies)

Referred by: _____ Date: _____

Full Name: _____

Gender: ☐M ☐F Marital Status: □ Single □ Married □ Widowed □ Separated □ Divorced Age: _____

Birth Date: ___/____/____ Height _____ Weight _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone.: _____

E-Mail: _____ Work Phone: (_____) _____

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INSURANCE / ATTORNEY INFORMATION:

Insured's Name: _____
(Last) (First) (Init)

Relation to patient: _____ D.O.B.: _____ Soc. Sec. #: _____

Insurance Company: _____

ID#: _____ Group #: _____

Do you have MedPay? ☐Yes ☐No Were you at fault? ☐ Yes ☐ No

Insurance Company of the Person at Fault: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

****

Have you retained an attorney? Yes / No

Your Attorney's Name: _____

Your Attorney's Phone: (_____) _____ Fax (_____) _____

Your Attorney's Address: _____

City: _____ State: _____ Zip: _____

ACCIDENT INFORMATION:

Date of Accident: _____/_____/_____ Time of Accident: _____ a.m. / p.m.

Your Vehicle: Year _____ Make _____ Model_____

Other Vehicle: Year _____ Make _____ Model_____

Seat Belt: ☐ Yes ☐ No Accident Type: ☐Rear ended ☐Head-on ☐Broad-sided

Damage to Your Vehicle: $ _____ Other Vehicle Damage: $ _____

Describe Accident: _____

_____

ACCIDENT SPECIFICS: (Mark a ✓ on each that applies to the accident)

Was this injury accident related? ☐ Yes ☐ No ☐ Auto ☐ Work ☐ Other

Was this a Job or Work related injury: ☐ Yes ☐ No Were you the: ☐ Driver ☐ Passenger

If passenger, where were you sitting: ☐ Front Seat ☐ Back Seat

Were you wearing your seatbelt: ☐ Yes ☐ No Did the airbag deploy: ☐ Yes ☐No

Impending Collision, were you: ☐ Aware ☐ Unaware ☐ Braced ☐ Not braced

Did your head: ☐ Strike Object ☐ Not strike Object ☐ Break Glass ☐ Other

Did you experience: ☐Shock ☐Loss of Consciousness ☐Whiplash ☐ Other

The Weather Conditions were they: ☐ Sunny ☐ Raining ☐ Snowing ☐ Foggy

The Road was: ☐ Dry ☐ Wet ☐ Icy Time of Day: ☐ Dawn ☐ Day ☐Dusk ☐ Night

State your emotions and physical state immediately following the accident: _____

_____

IMMEDIATELY FOLLOWING THE ACCIDENT: (Mark a ✓ on each that applies to the accident)

☐Ambulance / Paramedics were called
☐I was transported to Hospital by Ambulance
☐I was diagnosed at the Hospital
☐Medication was prescribed
☐I was treated at the scene
☐I went to Hospital in my own
☐I was treated at the Hospital
☐Follow-up was recommended

OTHER DOCTORS SEEN:

☐Orthopedist ☐Neurologist ☐Psychiatrist ☐Chiropractor ☐Acupuncturist ☐General Practitioner ☐Physical Therapist ☐Massage Therapist ☐Other

SYMPTOMATOLOGY: (Pain characteristics for major area of complaint)

The pain started: _____

The pain is made better by: _____

worse by: _____

The pain has the following qualities:_____

There is / There isn't parentheses (tingling/numbness) into: _____

The pain is (as far as timing is concerned: i.e. comes & goes, constant, etc.):_____

DAILY ACTIVITIES:

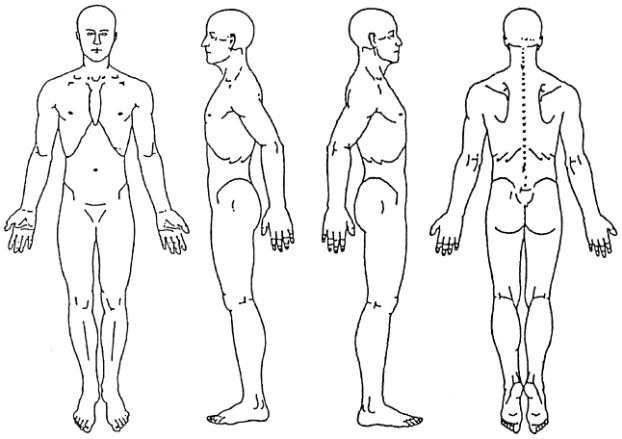
How many days out of an average week do you have pain? ☐ >1 ☐ 2-5 ☐ 5-7
How much time out of an average day are you in pain? ☐ Always ☐ Sometimes ☐ Never
What are the worst times of day for the pain? ☐ Morning ☐ Noon ☐ Evening ☐ Other
When do you feel the best? ☐ Morning ☐ Noon ☐ Evening ☐ Other

PAIN RATING:

On a scale of 0 – 10, rate your pain: (Please O the number that best describes your pain)

No Pain Severe Pain
0 1 2 3 4 5 6 7 8 9 10

Please use the legend symbols below to accurately mark the areas in which you feel these sensations:
Stabbing/Cutting-//// Tingling-**** Burning-XXXX Cramping- ^^^^
Numbness-NNNN Dull-####



Describe the overall severity of the pain:
☐Mild Nuisance
☐Mild to moderate, but can live with it
☐Moderate, having trouble coping with it ☐Severe, it is ruining my quality of life

How do the following activities affect your pain?

	No Change	Relieves	Increased	Duration
Sitting	☐	☐	☐	_____
Walking	☐	☐	☐	_____
Standing	☐	☐	☐	_____
Lying Down	☐	☐	☐	_____
Looking up	☐	☐	☐	_____
Looking Down	☐	☐	☐	_____
Lifting	☐	☐	☐	_____

PROGRESSION:

How is your pain compared to when the pain episode first started?
☐ Much Improved ☐ Somewhat Improved ☐ Much Worse ☐ Somewhat Worse ☐No Change

What do you do to relieve the pain? _____

Please mark a ✓ on each that applies to your daily activities:

- ☐ Have difficulty climbing stairs.
- ☐ Have to use handrails to get up stairs, etc.
- ☐ Have to hold onto something to sit or stand from a chair.
- ☐ Stay at home most of the time.
- ☐ Do not do jobs around the house.
- ☐ Walk slower than usual.
- ☐ Can only walk short distances.
- ☐ Have to sit most of the day.
- ☐ Can only stand for short periods of time.
- ☐ Stays in bed most of the day.
- ☐ Change position frequently to try and get comfortable.
- ☐ Have difficulty turning over in bed.
- ☐ Have to lie down and rest frequently.
- ☐ Have difficulty sleeping.
- ☐ Have to get other people to do things for me.
- ☐ Have difficulty getting dressed.
- ☐ Have to get dressed with someone's help.
- ☐ Have difficulty bending or kneeling.
- ☐ Have a loss of appetite.
- ☐ Have more irritable stages.

What are some recreational activities that you participated in before this current problem and which ones cannot be performed now to the same extent as before? _____

_____

How often do you have to stop activities and sit or lie down to control your symptoms?
☐ Several Times ☐ Occasionally ☐ Approximately _____ per day ☐ Never ☐ All Day

List your hobbies & exercise activities: _____

MEDICAL HISTORY:

List any medical professionals you have seen for this problem:

_____

List any medications you are currently taking:

_____

List the types of Diagnostic Testing that has been performed for this problem:
☐ X-Rays ☐ C.T. Scan ☐ Myelogram ☐ E.M.G. ☐ N.C.S.
☐ M.R.I. Scan ☐ Discogram ☐ Bone Scan

List Past Surgeries or Hospitalizations: ☐ None

_____

List previous back, neck and musculoskeletal problems: _____

_____

NOTES:

_____

_____

_____ _____
Signature Date

INFORMED CONSENT FOR CHIROPRACTIC CARE

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. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as the relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease of infirmity.

One disturbance to the nervous system is called a vertebral Subluxation. This occurs when one of more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of the nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by chiropractic adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral Subluxation. Our chiropractic method of correction is by specific adjustments or the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as rehabilitative procedures may be included.

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care professional.

All questions regarding the doctor's objective pertaining to may care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

Print Name Signature Date

Consent to evaluate and adjust a minor/child:

I, _____ being the parent of legal guardian of _____

Have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____ _____ _____

Print Name Signature Date

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To: _____

_____

_____

Re: Medical Reports and Doctor's Lien

I authorized the above doctor and/or their authorized representatives to furnish my attorney, any attorney or attorneys who subsequently are either associated with the said attorney or substituted in their place, with a full report of my examination, diagnosis, treatment, prognosis, itemized bill of charges incurred, etc. in regard to the accident in which I was involved on _____, and hold the above doctor free and harmless from any liability in such transfer of information.

Out of the proceeds of the settlement and/or judgment in my claim for personal injuries, I hereby assign, set over and transfer to the above doctor such monies due and owing to him or the group for medical, chiropractic, x-rays, physical therapy, supplies and/or laboratory fees rendered to me, either by reason of the above accident or otherwise. I further give to the above doctor a lien on any and all funds received by me or in my behave in association with the settlement or satisfaction of judgment arising from claims presented on my behalf.

I fully understand that I am directly responsible to said doctors/group for all medical bills submitted by them for services rendered to me. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually receive said fee. In the event legal action shall be brought in order to enforce this lien, then the prevailing party shall be entitled to reasonable costs and attorney fees in addition to any judgment rendered. It is acknowledged by the undersigned that this assignment and lien is further consideration for the services rendered by the above doctor in addition to the obligation to pay for the medical services.

Patient's personal injury claim medical payments are hereby assigned and will be paid directly to **Stoney Chiropractic, LLC**

Attorney agrees to notify the doctors immediately of the name and contacting information of any attorney substituted in his or her place.

_____ _____

PRINT PATIENT NAME DATE

_____ _____

SIGNATURE OF PATIENT SIGNATURE OF PARENT/GUARDIAN

ACKNOWLEDGEMENT OF ASSIGNMENT AND LIEN BY ATTORNEY

The undersigned being the attorney of record on his own behalf and on behalf of any other attorney or attorneys who are associated with the undersigned or who are substituted in his stead for the above patient, does hereby acknowledge receipt of a copy of the assignment and lien, and said attorney acknowledges that he/she obligates themselves to the terms of the assignment and lien in consideration for the rendering of medical services to their client by the above doctor and rendering of a report and bill to said attorney. In the event legal action shall be brought in order to enforce this lien, then the prevailing party shall be entitled to reasonable costs and attorney fees in addition to any judgment rendered. A photographic reproduction of this authorization may be used in place of the original. No charges or alterations of the monies billed herein will be accepted unless confirmed in writing by the doctor. Please date, sign and return on copy as soon as possible to the above referenced medical provider of service in order that treatment can continue on the herein contained lien basis.

_____ _____

ATTORNEY'S SIGNATURE DATE

DUTIES UNDER DURESS

Have you continued to do any of the following activities despite the pain caused by your accident?

WORK

Why have you continued to work?

☐ I would lose my job if I took time off.
☐ I couldn't support my family otherwise.
☐ I don't believe in taking time off even when I am injured or in pain.
☐ My business would fail if I did not work.
☐ I cannot take time off, because I care for my own children.
☐ Other: _____

I have experienced the following changes in my ability to perform at work:

☐ Mobility/Stability Problems
☐ Climbing
☐ Kneeling
☐ Lifting
☐ Walking for Long Periods
☐ Dexterity Problems
☐ Finger Movements
☐ Wrist Movements
☐ Problems with Fatigue
☐ Postural Difficulties
☐ Bending
☐ Sitting for Long Periods
☐ Standing for Long Periods
☐ Stooping
☐ Problems with Anxiety/Depression
☐ Problems with Vertigo or Spinning Sensations
☐ Dizziness
☐ Giddiness
☐ Sensation of Irregular Motion
☐ Sensation of Whirling Motion
☐ Problems with Tinnitus or Ringing in the Ears
☐ Problems with Reduced Concentration
☐ Can't Concentrate
☐ Can't Think Properly
☐ Making Mistakes
☐ Pain

HOUSEHOLD

I have experienced problems with the following activities outside my home:

☐ Painting the Outside of the House
☐ Landscaping
☐ Mowing the Grass
☐ Trimming the Bushes/Trees
☐ Washing Windows
☐ Gardening
☐ Taking Out the Trash
☐ Washing the Cars
☐ Maintaining the Cars
☐ Maintaining Yard Equipment
☐ Doing Other External House Work; Specify:_____

DOMESTIC DUTIES

I have experienced pain while performing the following activities inside my home, but have done them anyway:

☐ Laundry
☐ Dishwashing
☐ Vacuuming
☐ Washing Windows
☐ Cleaning
☐ Preparing Meals

STUDIES/EDUCATIONAL DUTIES

As a student I have experienced problems with one of the following activities since the collision:

☐ Carrying Books
☐ Sitting in Classes

☐ Looking Down to Read Textbooks

I have also experienced the following changes in my ability to perform at school as a result of injuries sustained in my accident:

☐ Mobility/Stability Problems
☐ Climbing
☐ Kneeling
☐ Lifting
☐ Walking for Long Periods
☐ Dexterity Problems
☐ Finger Movements
☐ Wrist Movements
☐ Problems with Fatigue
☐ Postural Difficulties
☐ Bending
☐ Sitting for Long Periods
☐ Standing for Long Periods
☐ Stooping
☐ Problems with Anxiety/Depression
☐ Problems with Vertigo or Spinning Sensations
☐ Dizziness
☐ Giddiness
☐ Sensation of Irregular Motion
☐ Sensation of Whirling Motion
☐ Problems with Tinnitus or Ringing in the Ears
☐ Problems with Reduced Concentration
☐ Can't Concentrate
☐ Can't Think Properly
☐ Making Mistakes
☐ Pain:

_____ _____
Print Name (Patient) Date

_____
Patient Signature