AUTO INJURY CHIROPRACTIC

MOTOR VEHICLE COLLISION INTAKE FORM

PRINT NAME: _____ **D.O.B:** _____

Auto Insurance: _____ **Claim #** _____

Adjusters Name & Number : _____

Attorney Representation? _____

Attorney Name & Number: _____

Time & Date Of Accident: _____

Location: _____

DESCRIBE ACCIDENT: _____

_____

Side of Impact? ☐ Front ☐ Rear ☐ Right ☐ Left

You were? ☐ Driver ☐ Front Passenger ☐ Rear Passenger

How many people were in your vehicle? _____

How many vehicles were involved in this accident? _____

YOUR VEHICLE

Year: _____ **Make:** _____ **Model:** _____

The vehicle you were in was ☐ Stopped ☐ Speeding Up ☐ Slowing Down ☐ Other

Estimated vehicle damage? $_____ **Who gave this estimate?** _____

Other Vehicle

☐ Small ☐ Midsize ☐ SUV ☐ Truck ☐ Other

Year/Make/Model? (If known): _____

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PRINT NAME: _____ **D.O.B:** _____

The other vehicle was ☐ Stopped ☐ Speeding Up ☐ Slowing Down ☐ Other

DETAILS OF IMPACT

Your vehicle: ☐ Hit Object ☐ Hit Another Vehicle ☐ Rolled ☐ Other

Explain: _____

Visibility: ☐ Good ☐ Poor

Explain: _____

Road Conditions? ☐ Dry ☐ Wet ☐ Ice ☐ Snow

- Were you ☐ Surprised or ☐ Braced for impact?

Seatbelt Fastened? ☐ Yes ☐ No

If YES, across your: ☐ Lap ☐ Shoulder ☐ Lap & Shoulder

Did your seat have a headrest? ☐ Yes ☐ No

If YES, what position? ☐ Low ☐ Mid ☐ High

Where were you looking? ☐ Right ☐ Left ☐ Straight ☐ Up ☐ Down

Was your back positioned on the seat? ☐ Yes ☐ No

Were BOTH hands ON the steering wheel? ☐ Yes ☐ No

If NO, which HAND was on the steering wheel? ☐ Right ☐ Left

Was your FOOT on the brake? ☐ Yes ☐ No

Did your body/head strike anything inside the vehicle? (headrest, dashboard, etc.) ☐ Yes ☐ No

If YES, Explain: _____

Did the vehicle have airbags? ☐ Yes ☐ No ☐ Unsure

- If YES, did they inflate? ☐ Yes ☐ No

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PRINT NAME: _____ **D.O.B:** _____

- If YES, were you struck by the airbag? ☐ Yes ☐ No

Did your SEAT break? ☐ Yes ☐ No

Were you wearing a hat or glasses? ☐ Yes ☐ No

If YES, were they still on after the impact? ☐ Yes ☐ No

AFTER THE ACCIDENT

Symptoms immediately after the accident? ☐ None ☐ Cuts ☐ Bruises

☐ Headache ☐ Leg pain ☐ Neck pain ☐ Confusion/Disorientation

☐ Arm pain ☐ Tingling/Numbness ☐ Mid back pain ☐ Low back pain ☐ Nausea

Were you knocked unconscious? ☐ Yes ☐ No

Did the police come to the scene? ☐ Yes ☐ No

Vehicles towed? ☐ None ☐ Your vehicle ☐ Other vehicle

Where did you go after? ☐ Home ☐ Work ☐ Hospital ☐ Other:_____

How did you get there?_____

Please describe your SYMPTOMS:

a) 1-3 hours afterward

_____

b) Later that day/night

_____

TREATMENT

Did you go to the ER? ☐ Yes ☐ No

If YES, Date? _____ If NO, why? _____

- X-RAY/CT/MRI done? ☐ Yes ☐ No

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PRINT NAME: _____ **D.O.B:** _____

Results? (IF KNOWN): _____

- **Medications Received?** ☐ **Yes** ☐ **No**

If YES, list: _____

2nd Provider: _____

Specialty: _____ **Date first seen:** _____ **Testing done?** ☐ **Yes** ☐ **No**

Diagnosis? _____ **Treatment:** _____

3rd Provider: _____

Specialty: _____ **Date first seen:** _____ **Testing Done?** ☐ **Yes** ☐ **No**

Diagnosis? _____ **Treatment:** _____

4th Provider: _____

Specialty: _____ **Date first seen:** _____ **Testing Done?** ☐ **Yes** ☐ **No**

Diagnosis? _____ **Treatment:** _____

- **IF YOU HAVE NOT BEEN SEEN FOR THESE INJURIES YET, WHY NOT?**

_____

PRIOR AUTOMOBILE ACCIDENTS

Have you EVER been involved in a Motor Vehicle Collision? ☐ **Yes** ☐ **No**

Year: _____ **Injured?** ☐ **Yes** ☐ **No** **How long was treatment?** _____

Do you have re-occurring symptoms from this injury? ☐ **Yes** ☐ **No**

Year: _____ **Injured?** ☐ **Yes** ☐ **No** **How long was treatment?** _____

Do you have re-occurring symptoms from this injury? ☐ **Yes** ☐ **No**

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PRINT NAME: _____ **D.O.B:** _____

PRIOR INJURIES

EVER had injuries to the same body parts that were affected in this collision? **Yes** **No**

Year: _____ **Injured Area:** _____ **How long was treatment?** _____

Do you have re-occurring symptoms from this injury? ☐ **Yes** ☐ **No**

Year: _____ **Injured Area:** _____ **How long was treatment?** _____

Do you have re-occurring symptoms from this injury? ☐ **Yes** ☐ **No**

EVER had a Workers Compensation Claim? ☐ **Yes** ☐ **No**

EVER had a Military Related Injury? ☐ **Yes** ☐ **No**

Signature of Patient: _____ **Date:** _____

Parent or guardian signature needed if patient is under 18

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AUTO INJURY CHIROPRACTIC

GENERAL INTAKE

NAME: **DOB:**
PREFERRED NAME:

Sex: _____ Gender: _____ Preferred Pronouns: _____

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

Tel. #: _____ Email: _____

Occupation: _____

Do you give permission for our office to update your general medical practitioner with the progress of your condition? □ **YES** □ **NO**

Name of General Medical Doctor: _____

Is this related to a motor vehicle collision or work injury? □ **YES** □ **NO**

May we send you email/text reminders the day before scheduled appointments? □ **YES** □ **NO**

ASSIGNMENT AND RELEASE

Scheduling an appointment reserves this time especially for you and no one else.

Our office requires **24 HRS. Notice** to cancel an appointment.

If 24 HRS. Notice is not given, a charge of $30 will be billed to your account.

I clearly understand and agree that all services provided will be charged directly to me and that I am personally responsible for payment. I agree to allow Auto Injury Chiropractic and/or provider to bill my insurance company as a courtesy and permit the release of medical records necessary to process my claims. I authorize Auto Injury Chiropractic, to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I authorize payments to be made directly to Pivot Health INC DBA Auto Injury Chiropractic and/or provider for treatment rendered. I may receive an additional bill for services not covered by my insurance.

I understand that my deductible, co-insurance and co-pays are due at the time of service.

Patient's Signature: _____ **Date:** _____
Parent or guardian signature needed if patient under 18 mm / dd / yyyy

AUTO INJURY CHIROPRACTIC

NAME: **DOB:**

PREFERRED NAME:

HEIGHT: **WEIGHT:**

Please describe your complaints below, starting with the most SEVERE.

Most SEVERE PROBLEM:

(Check **ONLY ONE**) □**Headache** □**Neck** □**Mid back** □**Low back** □**Other?** _____

a) Rank Severity **0-10** ***(0 NONE - 10 WORSE)*** **right now**? _____, and at **worse?** _____
b) **Describe** Problem (Check): □**DULL** □**SHARP** □**NUMBNESS** □**TINGLING** □**Other?**_____
c) How frequent does it occur? □**DAILY** □ **3X WK** □**2X WK** □**1X WK** □**OTHER?** _____
d) Is it □**CONSTANT 100%?** or □**COME & GO?** What **%** of the day is it present? □**25%** □**50%** □**75%**

Rate your **CURRENT** physical ability to complete the following activities.

From 0-10 (0= WITHOUT pain or restriction, 10= SEVERE pain or restrictions):

Working (__/10) Sleeping (__/10) Showering (__/10) Dressing (__/10) Cooking (__/10)

Cleaning (__/10) Laundry (__/10) House repairs (__/10) Yard maintenance (__/10)

PROBLEM: (Check **ONLY ONE**) □**Headache** □**Neck** □**Mid back** □**Low back** □**Other?** _____

a) Rank Severity **0-10** ***(0 NONE - 10 WORSE)*** **right now**? _____, and at **worse?** _____
b) **Describe** Problem (Check): □**DULL** □**SHARP** □**NUMBNESS** □**TINGLING** □**Other?**_____
c) How frequent does it occur? □**DAILY** □ **3X WK** □**2X WK** □**1X WK** □**OTHER?** _____
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b) **Describe** Problem (Check): □**DULL** □**SHARP** □**NUMBNESS** □**TINGLING** □**Other?**_____
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AUTO INJURY CHIROPRACTIC

HEALTH HISTORY

NAME: **DOB:**

PREFERRED NAME:

PAST HEALTH:

1. Do you **currently** or **have you ever,** suffered from any of the following? □ **YES** □ **NO** If YES, (Circle)

Asthma	**Depression**	**High blood pressure**	**Rheumatoid arthritis**
Aneurysm	**Diabetes**	**High Cholesterol**	**Skin condition**
Autoimmune disease	**Emphysema/COPD**	**HIV/AIDS**	**Stroke**
Bleeding disorder	**Genetic disorder**	**Liver disease**	**Tuberculosis**
Cancer	**Heart disease/attack**	**Osteoporosis**	**Other:** _____

When were you diagnosed with the above condition? _____

2. Have you ever had **SURGERY** or **RECENT MODERATE TRAUMA**? □ **YES** □**NO**

EXPLAIN: _____

_____

3. Do you take any **MEDICATIONS** or **VITAMINS / HERBS?** □ **YES** □**NO**

EXPLAIN: _____

_____

4. Do you have any **ALLERGIES?** □**YES** □**NO**

EXPLAIN: _____

FAMILY HISTORY:

Has any of your IMMEDIATE BLOOD RELATIVES suffered from any of the following? If YES, (Circle)

Autoimmune disease	**Cancer**	**High cholesterol**	**High Blood Pressure**	**Osteoporosis**
Bleeding disorder	**Diabetes**	**Heart Disease/attack**	**Neurologic Disorders**	**Stroke**

ANY deceased blood relatives? □**YES** □**NO** If (YES), Age & Cause? _____

PERSONAL HISTORY:

1. Your **HABITS:**
   a. How many alcoholic drinks do you consume per week? _____
   b. **Tobacco usage:** □ Current □ Former □ Never
   c. **Vape Smoke:** □ Current □ Former □ Never
2. Do you **EXERCISE** regularly? □ **YES** □**NO** What **Type/Frequency**? _____

AUTO INJURY CHIROPRACTIC

PROTECTED HEALTH INFORMATION DISCLOSURE

PLEASE REVIEW CAREFULLY AS IT PERTAINS TO THE USAGE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) AND GIVES CONSENT TO TREATMENT

NAME: **DOB:**

PREFERRED NAME:

INT. _____ I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to Auto Injury Chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors, LMTs, and locum providers see fit. **I hereby authorize Auto Injury Chiropractic to release all information necessary to any insurance company, attorney, or adjuster for claim reimbursement of charges incurred by me.** I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. My questions (if any) were answered to my satisfaction. I intend this consent to cover the course of treatment for my present condition and for any future conditions for which I seek treatment.

TREATMENT CONSENT & FINANCIAL POLICY

INT. _____ All procedures and treatment interventions [nutraceuticals, soft tissue manipulation (including massage, suction cups, instrument assisted), exercises, spinal manipulation, physical therapy modalities (electric stimulation and ultrasound are a few examples), etc.] carry with them both risks and benefits. Risks include but are not limited to: injury, fracture, burns, worsening of condition, adverse reactions, stroke and/or death. Not receiving or accepting treatment recommendations also carries inherent risks including but not limited to: possible worsening of condition or disease progression, which may result in reduced quality of life and/or premature death. If uncomfortable with a recommended treatment or procedure, there may be alternative treatments available. You are encouraged to ask questions if you would like additional information. No guarantees can be assured regarding the outcomes of any treatment(s) or procedure(s) recommended or performed.

INT. _____ Fees are charged for professional services, and full payment with cash, check, or credit card is due at the time these services are rendered. **You are responsible for payment of office fees, treatments, imaging, and lab tests regardless of insurance coverage.** As a courtesy, we provide insurance billing service. However, each insurance plan offers different levels of reimbursement and/or coverage for services. Many "preventative approaches" to healthcare are not covered by insurance plans. **Any expense not covered by your insurance plan is your responsibility to pay in full. Deductible, co-pays, and non-covered services must be paid at time of service. If patient is a minor, the parent/ guardian signing below is assuming financial responsibility.**

Signature of Patient: _____ **Date:** _____

Parent or guardian signature needed if patient under 18 mm / dd / yyyy