Results Chiropractic and Rehabilitation

Injury/Accident Paperwork

Personal Information

Name: _____
Last First MI

Mailing Address: _____

_____

Phone: (H)_____ (W)_____ (Other) _____

Can we call you at work? ❑ Yes ❑ No

Date of Birth: _____ Sex: ❑ Male ❑ Female ❑ Decline to Answer

Current Gender Identification:_____ Preferred Pronouns:_____

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact:
Name: _____ Relation: _____

Phone: (H)_____ (W)_____ (Other) _____

Accident Information

Your Info:

Name of driver of vehicle in which you were injured (self or other) _____

Insurance Company _____

Phone No. _____Address _____

Policy No._____Claim No. _____

Other Party Info:

Name: _____ Insurance Company: _____

Phone No._____ Address: _____

Policy No. _____ Claim No _____

Name of person who has made contact with you: _____

Were police notified? YES/NO Did head strike windshield or object? YES/NO

Were you knocked unconscious? YES/NO If so, for how long _____

1. Give time and date of accident: _____ AM/PM _____/_____/_____
2. Number of people in your vehicle? _____
3. You were: (driver, passenger, front seat, back seat) _____
4. You were struck from: (behind, front, left side, right side) _____
5. How fast was your car traveling? _____
6. How fast was the other car traveling? _____
7. What direction were you looking when the accident occurred? _____
8. Were you wearing a seat belt or other protective device? _____
9. Did your head hit the headrest or the windshield? _____
10. Did you feel pain immediately after the accident? YES/NO
11. If pain was delayed, when did you begin feeling it? _____
12. WHERE did you feel pain after the accident? _____
13. Where were you taken after the accident? _____
14. Was treatment given? _____
15. Was any doctor consulted after the treatment: YES/NO. Who? _____
16. Doctor's Diagnosis: _____
17. What treatment was given: _____
18. Have you had complaints in the involved area before? _____
19. If so, what complaints? _____
20. Before the injury, were you capable of working on a equal basis with other your age: Y/N
21. Are your work activities restricted as a result of the accident: _____
22. Since the injury, are your symptoms: (improving, worse, same)

Health History

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

❑ Neck Pain/Stiffness	❑ Pins/Needles in Arms	❑ Light Bothers Eyes	❑ Sudden Weight Loss	❑ Nausea
❑ Back Pain/Stiffness	❑ Pins/Needles in Legs	❑ Depression	❑ Loss of Taste	❑ Cold Feet
❑ Arm/Hand Pain	❑ Fatigue	❑ Nervousness	❑ Loss of Memory	❑ Chest Pain
❑ Leg/Knee Pain	❑ Sleeping Difficulties	❑ Tension	❑ Jaw Problems	❑ Fever
❑ Headaches	❑ Loss of Smell	❑ Cold Sweats	❑ Constipation	❑ Fainting
❑ Dizziness	❑ Allergies	❑ Stomach Problems	❑ Shortness of Breath	
❑ Asthma	❑ Blurred Vision	❑ Night Pain	❑ Bowel/Bladder Changes	

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Cancer	❑ Hepatitis	❑ Osteoporosis	❑ Stroke
❑ Alcoholism	❑ Cataracts	❑ Hernia	❑ Pacemaker	❑ Suicide Attempt
❑ Allergy Shots	❑ Chemical Dependency	❑ Herniated Disc	❑ Parkinson's Disease	❑ Thyroid Problems
❑ Anemia	❑ Chicken Pox	❑ Herpes	❑ Pinched Nerve	❑ Tonsillitis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tuberculosis
❑ Appendicitis	❑ Emphysema	❑ Kidney Disease	❑ Polio	❑ Tumors/Growths
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostate Problems	❑ Typhoid Fever
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Ulcers
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraines	❑ Psychiatric Care	❑ Vaginal Infections
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Venereal Disease
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Whooping Cough
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Scarlet Fever	
	❑ Heart Disease	❑ Mumps	❑ Other _____	

Are you currently under drug and/or medical care? ❑ Yes ❑ No If yes, explain _____

Please list any medications you are currently taking: _____

_____

Please list any surgeries and/or hospitalizations you have had (type & date): _____

_____

_____

Please list any allergies: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

❑ Heart Disease_____ ❑ Diabetes _____❑ Cancer
❑ Arthritis ___ ❑ Other _____

Do you exercise: ❑ Frequently ❑ Moderately ❑ Occasionally ❑ None

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor❑ Heavy Labor

Do you sleep on your: ❑ Back ❑ Side ❑ Stomach Do you use a cervical pillow? ❑ Yes ❑ No

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes ____ packs/day

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ **DATE** _____

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____

Results Chiropractic and Rehabilitation,P.A.

4210 Rainbow Boulevard ◊ Kansas City, KS 66103
Phone: (913) 789-9929 ◊ Fax: (913) 789-8992

Doctor's Lien

To: Attorney: _____
name **address**

To: Insurance Carrier: _____
name **address**

Insured: _____
name **address**

Injured/Patient: _____
name **address**

Amount of Lien: _____

I do hereby authorize the above doctor to furnish you, my attorney/insurance carrier with a full report of his case history, examination, diagnosis, treatment and prognosis of myself in regard to my automobile accident which occurred on _____.

I hereby give a lien to said doctor on my settlement, claim, judgment or verdict as a result of said accident and authorize and direct you, my attorney/insurance carriers to pay directly to said doctor such sums as may be due and owing him for service rendered me, and to withhold such sums from such settlement, claim, judgment or verdict as may be necessary to protect said doctor adequately. This lien cannot be made null or void without the express written consent of myself, and any verbal statement does not affect this agreement.

I fully understand that I am directly responsible to said doctor for all chiropractic bills submitted by him for service rendered me, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, claim, judgment or verdict by which I may eventually recover said fee.

Dated:_____ Patients Signature:_____

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said named doctor.

Dated:_____ Authorized Signature:_____

NOTICE: Please sign, date and return one copy to doctor's office at once. Keep one copy for your records.

STATE OF_____)
) ss
COUNTY OF_____)

I, the undersigned, an officer authorized to administer oaths, certify that _____, having been first duly sworn, signed and executed the within instrument and that he willingly signed and that he executed it as his free and voluntary act for the purposes therein expressed, and that to the best of my knowledge, _____ was at the time eighteen (18) or more years of age, of sound mind, and under no constraint or undue influence.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my official seal this ____ day of _____, 20___.

_____
Notary Public

My Commission Expires:

_____