Motor Vehicle Accident History

Today's Date:_______________ Date Of Accident:____________________ Date Of Birth_____________

Full Name_______________________________________SS#:_____________________________________

Street Address____

City____ State_________________ Zip_____________

Home Phone: _____________________ Work Phone____________________ Cell_____________________

Email_______________________________________ Marital Status: _____________

Occupation:____________________________________Employer__________________________________

Are You Presently Working? _______ If Yes, Are You Working In Pain?______

Have You Lost Time From Work? _____ (If Yes Provide Details And Amount Of Time Lost)

____

Insurance Agent:___________________________________ Phone Number__________________________

Auto Insurance Company Name____

Was A Report Made?________ Is So What Is The Claim Number?________________________________

The Accident:

You Were The: ___Driver ___ Passenger In Front ___ Passenger in Back

Who Else Was In The Car With You At The Time Of The Accident? _____________________________

Were These People Injured?_________ Were They Treated For Injuries?___________

Were You Aware The Accident Was About To Happen? ______

Briefly Describe The Accident: ____
____
____

Were You Driving A Work Vehicle? _____________

Were You Performing A Work-Related Function In Your Vehicle? _________

Were You Wearing A Lap Belt? Yes______ No______ Shoulder Belt? Yes______ No_________

Did You Strike Any Object In The Vehicle? Yes_____ No_____ Cannot Remember _____

_____ Steering Wheel _____ Review Mirror _____ Dash _____ Side Pillars
_____ Windshield _____ Side Windows _____ Headrest _____ Roof

Other:____

What Part Of Your Body Was Struck?____

Did You Feel Immediate Pain? _____ If Yes-Where____

Were You Cut Or Bleeding?______________ If Yes-Where?__________________________________

Were You Rendered Unconscious?_______

Where Did You Go After The Accident? Home____ Work____ Hospital _____ Other__________

If You Were Taken To The Hospital How Were You Transported? ____________________________

Hospital Name_____________________________ If Admitted How Long Did You Stay?_________

What Care Did You Receive At The Hospital?

___ Exam ___ Stitches ___X-Rays ___Physical Therapy ___Neck Collar
___ Casting ___ Medication Other____

After Your Release Where Did You Go? ____ Home ___ Work Other______________________

After The Accident

What Treatment Have You Received To Date?

(1) Dr. _________________________ Specialty_______________________ Date Seen__________
Still Treating? _______ Special Testing: ____ MRI ___CAT SCAN ___X-Rays
Did This Doctor Refer You Elsewhere? _______ Did Treatment Received Help?_______

2) Dr. _________________________ Specialty_______________________ Date Seen__________
Still Treating? _______ Special Testing: ____ MRI ___CAT SCAN ___X-Rays
Did This Doctor Refer You Elsewhere? _______ Did Treatment Received Help?_______

What Are Your Present Complaints? Please Check All That Apply:

___ Chest Pain
___ Arm/Hand Pain
___ Sleep Problems
___ Ears Ringing
___ Constipation
___ Headache
___ Leg/Foot Pain
___ Upset Stomach
___ Mid Back Pain
___ Depression
___ Arm/ Hand Tingling or Numbness
___ Leg/Foot Tingling or Numbness
___ Loss Of Taste/Hearing/Smell
___ Loss Of Feeling/Sight/Memory/Breath
___ Tension
___ Fatigue
___ Diarrhea
___ Low Back

Do You Have Difficulties Performing Your Activities Of Daily Living? ______
If Yes Explain:____

Do You Have Any Work Related Difficulties?______
If Yes Explain:____

Do You Have Any Problems Participating In Your Hobbies?
If Yes Explain:____

Was Your Head Turned At The Time Of Impact? _______ Was Your Body Turned?________

On A Scale Of 1-10 (10 Being The Worst) What Is Your Present Level Of Pain? ______

Do You Have An Attorney Representing You? ________

Attorney Name________________________________ Phone Number________________________

Past History

Have You Been In Any Previous Accidents? ______

If Yes Please Give Dates & Details:____
____

Have You Had Any Surgeries? _________

If Yes Please Give Dates & Details:____
____

Have You Been Treated For Neck Or Back Problems Before? _________

If Yes Please Give Dates & Details:____
____

Have You Had Any Previous Injuries? (Such As Falls, Broken Bones, Severe Sprains) _____________

If Yes Please Give Dates & Details:____
____

Have You Enjoyed Good Health Before This Accident? ______

I Attest That The Information Provided Is True To The Best Of My Knowledge and Recollection:

Signed____ Date______________________________

I _____________   , hereby authorize this office to release my personal or dependant's medical records or any pertinent information regarding my care to my insurance company, adjuster, attorney, hospital, or physician upon written request with a signed authorization release.

I authorize any medical facility to relinquish medical records, diagnostic reports or other pertinent information regarding mine or my dependents care to this office.

I direct and authorize my attorney to pay directly to LifeStyle Chiropractic all such sums as may be due and owing for services rendered and/or supplies given to me in the course of treatment. This authorization will remain in force until all such sums are paid in full.

As a courtesy we will gladly check your insurance benefits. However please understand that knowing your benefits is ultimately your responsibility. The insurance cpmpanies do at times quote incorrect or inadequate benefit information. Therefore any and all insurance co-pays, co-insurance or deductible amounts remain your responsibility. If your insurance charges you a different co-pay, co-insurance or deductible than originally quoted, you are responsible for the difference. Any overpayments will be posted to your account or refunded by request.

I understand that I am responsible for payment of all fees incurred by me or my dependant(s) at this office. Please understand that at times your insurance Company may forward payment of our fees directly to your residence. Please contact Us if this happens so that we can determine which of your fees this payment applies to.

Patient Signature: ____

Date:____________________

Your Informed Consent

Although Chiropractic is reported to be the safest health care system in the world, some say there are very slight risks associated with it. We feel that it is responsible to let you know:

a. Risk of stroke is reported to be about 1 in 400 thousand to about 5.8 million and the cause has yet to be determined.
b. While extremely rare, there have been reports of ligament sprains, and even rib fractures reported.
c. There have been rare reports of disc injuries although no clinical scientific study has ever demonstrated chiropractic care to be the cause.

Chiropractic care has been proven to be both, clinically and very cost effective. The risk of injuries and complications is so small that chiropractors carry the lowest malpractice insurance premiums of all the health care professions in the world.

Compared to traditional medical/drug/surgical care, which has a yearly death rate of approximately 200,000 people in North America, Chiropractic is your safest health care system.

I have read and understand the above consent, and have had the opportunity to discuss it with my chiropractor.

I consent to the care recommended by my chiropractor and extend this consent to include all doctors of this Chiropractic & Wellness Centre. This consent applies to all present and future care for me and my family.

Your Name: ________________________________ Date: ____________________
Your Signature: ____
Witness: ___________________________________

Consent for Radiology

I,___________________________________, give LifeStyle Chiropractic & Wellness Center my consent to take any and all x-rays needed to better understand my condition. I have been fully I informed of the possible risks and safety standards of this office.

I also give my consent for films of my child (children) for the same reasons, if applicable.

For Ladies only:

To my best knowledge I am not pregnant and know of no contraindications for x-rays at this time.

Patient Signature: _________________________ Date:_____________________

Personal Injury
Authorization For Payment

I, hereby, irrevocably authorize and direct my attorney, as my representative, to allow and/or pay any and all insurance PIP reimbursements that my policy allows, as related to my case fees incurred at LifeStyle Chiropractic, without interruption, delay and/or reduction to LifeStyle Chiropractic. This authorization/notification/direction for you, my attorney, will stay in force as long as I remain a patient with LifeStyle Chiropractic and/or have monies due them. This letter of direction and authorization cannot be modified or revoked without the expressed written consent of LifeStyle Chiropractic.

Signed_____________________________________ Date________________________

Personal Injury Insurance Confirmation

Patient Name:____

Today's Date:________________

Date Of Accident:_____________

Insurance Company Name:____

Spoke With:____

Agents Name & Phone:____

Adjuster:____

Adjuster Phone:___________________________Fax:__________________________

Claim #:____

Accident Reported:_________

Benefits Available:_________

Mailing Address:____

____

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Notes: