BodyDoc Chiropractic
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PERSONAL INJURY/ ACCIDENT MEDICAL HISTORY INTAKE FORM

FULL NAME_____DATE_____

Gender: MALE__ FEMALE__ BIRTHDATE_____AGE_____

ADDRESS_____

CITY_____STATE_____ZIP_____ Referred by_____

Home Phone_____ Cell Phone_____

Email_____ _

INSURANCE COMPANY:_____

CLAIM #_____ADJUSTER_____

PHONE _____ FAX_____

ADDRESS_____
Do you have MedPay? YES___ NO____ Were you at fault? YES___ NO____

INSURANCE COMPANY OF PERSON AT FAULT_____

CLAIM #_____ADJUSTER_____

PHONE _____ FAX_____

ADDRESS_____
****

Have you retained an ATTORNEY? Yes___ NO___ If yes:
Name_____Firm_____

Phone #_____Fax#_____

Address_____

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: _____

_____

State your emotions & physical state after the first few days: _____

_____

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 ☐ Physiatrist ☐ Chiropractor

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: _____

_____

_____

SOCIAL HISTORY:

☐ Smoker ☐ Non-Smoker ☐ Do not drink alcohol ☐ Drink alcohol

How much? _____ How often? _____

☐ Do not take drugs ☐ Take Drugs How much? _____ How often? _____

Number of Children: _____

☐ 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: _____

_____

and worse by _____

_____

The pain has the following qualities: _____

_____

There is / There isn't radiation into: _____

_____

There is / There isn't referred pain into: _____

_____

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

_____

The pain is located: _____

_____

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:

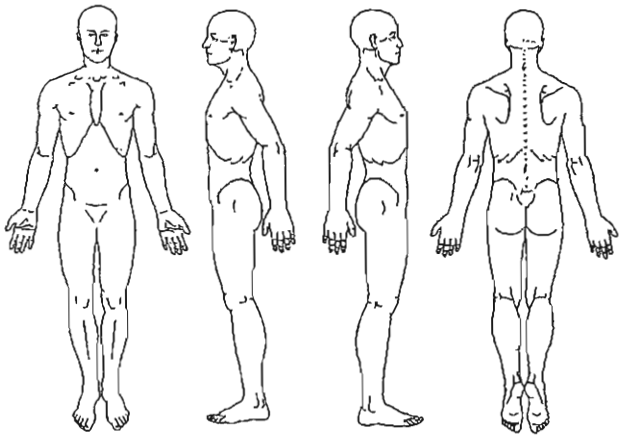
On a scale of 0 - 10, rate your pain: (Please O the number that best describes your pain)

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? _____

_____

_____

MEDICAL HISTORY:

List any medical professionals you have seen for this problem:

_____

_____

List any medications you are currently taking:

_____

_____

List the treatments you have had for your problem:

☐ Chiropractic ☐ Osteopathy ☐ Trigger Point Injections ☐ Epidural Injections
☐ Acupuncture ☐ Naturopathy ☐ Hot packs ☐ Ultrasound ☐ Diathermy ☐ Massage
☐ Electrical Stimulation ☐ Biofeedback ☐ TENS Unit ☐ Body Mechanics Training
☐ Strengthening Exercises ☐ Aerobics ☐ Gravity Inversion / Traction ☐ Bed Rest
☐ Back Brace ☐ Other: _____

List the types of Diagnostic Testing that has been performed for this problem:

☐ X-Rays ☐ C.T. Scan ☐ Myelogram ☐ M.R.I. Scan ☐ Discogram ☐ Bone Scan
☐ E.M.G. ☐ N.C.S.

List Past Surgeries: ☐ None

_____

_____

List Past Hospitalizations: ☐ None

_____

_____

List previous back, neck and musculoskeletal problems: _____

_____

_____

MEDICAL HISTORY:

Please mark a ✓ if you have had any of the following symptoms in the past 5 years.

☐ Unexplained fevers ☐ Night sweats ☐ Weight loss of 10 lbs or more ☐ Loss of appetite

_____

Informed Consent For Chiropractic Care

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. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there may be a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

Prior to receiving chiropractic care in this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed before treatment. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan to help you become healthier prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments and other modalities, as reported following my assessment.

_____	_____
Patient Name (printed)	Relationship to patient
_____	_____
Patient or legal Guardian Signature	Date
_____	_____
Witness Signature (office staff)	Date

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE X (Date)

(Or Patient Representative) (Indicate relationship if signing for patient)

OFFICE SIGNATURE X (Date)

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE **X** (Date)

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE