

# NEW PATIENT INFORMATION

For Office use Only  
Patient #

Patient's First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer Name \_\_\_\_\_

Job Title \_\_\_\_\_ Work Phone # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender  Male  Female Handedness? R L

Weight \_\_\_\_\_ Height \_\_\_\_\_ Marital Status S M W D

Spouse's Name \_\_\_\_\_ Spouse's Date of Birth \_\_\_\_\_

Person responsible for this account \_\_\_\_\_

Health Insurance Company \_\_\_\_\_ Phone number \_\_\_\_\_

Policy/Member ID # \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Adjuster \_\_\_\_\_ Phone Number \_\_\_\_\_

Name of the insurance card holder \_\_\_\_\_

Social Security # of card holder \_\_\_\_\_

Name of their employer \_\_\_\_\_ Employer Phone # \_\_\_\_\_

Children names and ages \_\_\_\_\_

Car Insurance Company \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Adjuster \_\_\_\_\_ Phone # \_\_\_\_\_

Agent \_\_\_\_\_ Phone # \_\_\_\_\_

Policy # \_\_\_\_\_ Claim # \_\_\_\_\_

Drivers License # \_\_\_\_\_

Name of Insured on your Car Policy \_\_\_\_\_ Date of Loss/Accident? \_\_\_\_\_

Medical Coverage? \_\_\_\_\_ Uninsured Motorist Coverage? \_\_\_\_\_

Underinsured Motorist Coverage? \_\_\_\_\_

Personal Injury Protection (PIP) Y N \$ \_\_\_\_\_

Medical expenses to date as a result of the accident? \$ \_\_\_\_\_

Lost wages since accident \$ \_\_\_\_\_

What is the repair amount of your car? \$ \_\_\_\_\_

Lawyer/ Law Firm \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

In case of emergency, whom should we contact? \_\_\_\_\_

Phone # \_\_\_\_\_

Family physician \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Date you first saw any Doctor after accident \_\_\_\_\_

Is this Workman's Compensation? \_\_\_\_\_ Is this Personal Injury? \_\_\_\_\_

Have you received any medical treatment since your accident? Y N

Hospital \_\_\_\_\_ Cost \_\_\_\_\_

Medical Doctor \_\_\_\_\_ Cost \_\_\_\_\_

Chiropractor \_\_\_\_\_ Cost \_\_\_\_\_

Other \_\_\_\_\_ Cost \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# ACCIDENT QUESTIONNAIRE

Patient's Name \_\_\_\_\_ Date of incident \_\_\_\_\_ Today's Date \_\_\_\_\_

## DESCRIBE YOUR VEHICLE

### 1. Vehicle Type :

- a. Sports Car
- b. Coupe
- c. Sedan
- d. Sports Utility Vehicle
- e. Station Wagon
- f. Pick-up truck
- g. Bus
- h. Other: \_\_\_\_\_

Make: \_\_\_\_\_ Year: \_\_\_\_\_

Model: \_\_\_\_\_ Estimated Speed: \_\_\_\_\_

### 2. Vehicle Size:

- a. Compact
- b. Mid-Sized
- c. Full-Sized

## DESCRIBE THE ACCIDENT

### 3. Date of Accident: \_\_\_\_\_

### 4. Actions of patient's vehicle:

- a. crossing an intersection
- b. stopped at an intersection
- c. stopped for a pedestrian
- d. stopped for traffic
- e. traveling at posted speed limit
- f. traveling faster than the posted speed limit
- g. turning

### 5. How was the patient's vehicle hit:

- a. hit head-on
- b. was hit on the left front
- c. was hit on the right front
- d. was hit on the left rear
- e. was hit on the right rear
- f. was rear-ended
- g. Other: \_\_\_\_\_

### 6. Damage to patient's vehicle:

- a. complete
- b. extensive
- c. minimal
- d. moderate

### 7. Describe the second vehicle:

- a. compact
- b. full size
- c. mid size
- d. semi trailer
- e. pick-up truck

Make: \_\_\_\_\_ Year: \_\_\_\_\_

Model: \_\_\_\_\_ Estimated Speed: \_\_\_\_\_

### 8. Damage to the other vehicle?

- a. complete
- b. extensive
- c. minimal
- d. moderate

### 9. Weather Conditions

- a. Clear
- b. Cloudy
- c. Drizzling
- d. Foggy
- e. Rainy
- f. Snowy
- g. Stormy
- h. Sunny

### 10. Road Conditions

- a. Damp
- b. Dry
- c. Dry with icy patches
- d. Iced over
- e. Snowed over
- f. Wet

## DESCRIBE THE MOMENT OF IMPACT

### 11. Body position at time of impact:

- a. leaning forward
- b. slouched down in seat
- c. straight
- d. turned to the left
- e. turned to the right

### 12. Direction body was thrown:

- a. backward then forward
- b. forward then backward
- c. to the left
- d. to the right
- e. about the vehicle
- f. outside the vehicle
- g. under the vehicle

### 13. Head position at impact:

- a. straight
- b. tilted forward
- c. turned to the left
- d. turned to the right

### 14. Direction head was thrown:

- a. backward then forward
- b. forward then backward
- c. side to side

### 15. Type of restraint:

- a. lap belt
- b. shoulder belt
- c. shoulder lap belt

### 16. Place patient was seated in the vehicle:

- a. Driver
- b. front passenger
- c. back passenger driver side
- d. back passenger right side
- e. back passenger middle
- f. other \_\_\_\_\_

### 17. Did Airbags deploy:

- a. yes
- b. no

### 18. Were you seen at a Medical Facility following your accident:

- a. Yes
- b. No

If so name and address of the facility:

\_\_\_\_\_  
\_\_\_\_\_

Patient Signature \_\_\_\_\_

## SYMPTOMS

Patient's Name \_\_\_\_\_ Date of incident \_\_\_\_\_ Today's Date \_\_\_\_\_

### CIRCLE ALL YOU COMPLIANTS

#### 3. DO YOU HAVE LACERATIONS, CUTS OR BRUISING? :

- a. Head or Face
- b. Neck
- c. Seat belt bruising
- d. Cuts or bruising on your chest
- e. Cuts or bruising on arms
- f. Cuts or bruising on legs
- g. Other: \_\_\_\_\_

#### 4. HEAD INJURIES: (now or at the time of the accident)

- a. Were you knocked out or unconscious
- b. Headaches
- c. Face pain
- d. Pupils different sizes
- e. Dizziness
- f. Difficulty walking
- g. Balance problems
- h. Room spins
- i. Disoriented Confusion
- j. Day dreaming
- k. Attention problems
- l. Hearing problems
- m. Change in sense of smell or taste
- n. Difficulty speaking
- o. Memory problems
- p. Very tired or fatigued
- q. Appetite change
- r. Sleep difficulties
- s. Visual Disturbances, blurry or double vision
- t. Flashbacks to accident
- u. Problems to read or write
- v. Problems adding or subtracting
- w. Problems learning new things
- x. Problems understanding
- y. Problems remembering numbers
- z. Difficulty Concentrating
- aa. Difficulty remembering things
- bb. Difficulty making decisions
- cc. Change in Sexual Functioning
- dd. Nausea / Vomiting

- ee. Change of personality
  - ff. Wanting to be alone
  - gg. Mood swings
  - hh. Sadness
  - ii. Agitation
  - jj. Anger
  - kk. Helplessness
  - ll. Reduce confidence
  - mm. Apathy
  - nn. Irritability
  - oo. Sleepiness
  - pp. Frustration
  - qq. Impatience
  - rr. Other head related issues
- 

#### 5. JAW PROBLEMS:

- a. Jaw pain
- b. Clicking
- c. Pain while chewing
- d. Pain while talking
- e. Pain while yawning
- f. Pain while moving jaw from side to side

#### 6. NECK INJURIES:

- h. Neck pain
- i. Neck pain, numbness, tingling, weakness that radiates or goes down to RIGHT shoulder, arm, forearm or hand
- j. Neck pain, numbness, tingling, weakness that radiates or goes down to LEFT shoulder, arm, forearm or hand
- k. Neck pain, numbness, tingling, weakness that radiates or goes down to RIGHT UPPER BACK
- l. Neck pain, numbness, tingling, weakness that radiates or goes down to LEFT UPPER BACK
- m. Neck pain that causes headaches
- n. Neck spasms or shoulder spasms
- o. Popping, clicking or clunking sound with neck movement

7. SHOULDER INJURIES

- h. Shoulder pain LEFT RIGHT BOTH
  - i. Shoulder pain with movement L R BOTH
  - j. Shoulder spasms LEFT RIGHT BOTH
  - k. Sharp shoulder pain
  - l. Dull shoulder pain
  - m. Achy shoulder pain
  - n. Pins and needles shoulder pain
  - o. Shoulder pain that radiates or shoots pain into arm
  - p. Other:
- 

8. UPPER ARM PAIN: RIGHT LEFT BOTH

- e. Dull
  - f. Ache
  - g. Sharp
  - h. Stabbing
  - i. Other
- 

9. ELBOW PAIN: RIGHT LEFT BOTH

- a. Dull
  - b. Ache
  - c. Sharp
  - d. Stabbing
  - e. Other
- 

10. FOREARM: RIGHT LEFT BOTH

- a. Dull
  - b. Ache
  - c. Sharp
  - d. Stabbing
  - e. Other
- 

11. WRIST PAIN: RIGHT LEFT BOTH

- a. Dull
  - b. Ache
  - c. Sharp
  - d. Stabbing
  - e. Other
- 

12. HAND PAIN: RIGHT LEFT BOTH

- a. Dull
  - b. Ache
  - c. Sharp
  - d. Stabbing
  - e. Other
- 

13. MID BACK PAIN OR UPPER BACK PAIN

- a. Upper or mid back pain
- b. Upper back pain, numbness, tingling, weakness that radiates or goes down to RIGHT shoulder, arm, forearm or hand
- c. Upper back pain, numbness, tingling, weakness that radiates or goes down to LEFT shoulder, arm, forearm or hand
- d. Upper or mid back spasms

14. LOW BACK PAIN:

- a. Low back pain
- b. Low back pain, numbness, tingling, weakness that radiates or goes down to RIGHT buttock, thigh, leg or foot
- c. Low back pain, numbness, tingling, weakness that radiates or goes down to LEFT buttock, thigh, leg or foot
- d. Low back spasms

15. PELVIC OR SACRAL PAIN

- a. Pelvic pain, numbness, tingling, weakness that radiates or goes down to RIGHT buttock, thigh, leg or foot
- b. Pelvic pain, numbness, tingling, weakness that radiates or goes down to LEFT buttock, thigh, leg or foot
- c. Sacral pain (tail bone)
- d. Coccygeal or coccyx (tail bone) pain

16. HIP PAIN: RIGHT LEFT BOTH

- a. Hip pain
- b. Hip pain, numbness, tingling, weakness that radiates or goes down to buttock, thigh, leg or foot

17. UPPER LEG PAIN: RIGHT LEFT BOTH

- a. Upper leg pain that radiates to knee
- b. Upper leg spasms

18. KNEE PAIN: RIGHT LEFT BOTH

- a. Knee pain that radiates to calf
- b. Knee pain that radiates to calf and ankle
- c. Knee pain that radiates to calf, ankle and foot

19. ANKLE PAIN: RIGHT LEFT BOTH

- a. Ankle pain that radiates to foot
- b. Ankle and foot pain

20. FOOT PAIN: RIGHT LEFT BOTH

21. CHEST PAIN

22. STOMACH PAIN

23. OTHER SYMPTOMS:

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# HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. [www.hhs.gov](http://www.hhs.gov) We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

## Please check mark the following that you agree to:

- We can use email to communicate information to you.
- We can use voice message to communicate information to you.

## Please list all parties that are available to communicate information on your behalf:

I, \_\_\_\_\_ date \_\_\_\_\_ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

# Chiropractic Consent Form

## **The material risks inherent in Chiropractic adjustment:**

As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

## **The probability of those risks occurring:**

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

Signature \_\_\_\_\_

Date \_\_\_\_\_

# X-RAY CONSENT FORM



Patient name: \_\_\_\_\_

During your examination, the doctor may feel that x-rays will be needed in order to diagnosis your condition. We would like to make you aware that x-rays may be required, in order, to administer treatment. In order to perform x-rays on any patient our office requires the patients consent for such tests to be performed.

**Please Choose One:**

\_\_\_\_\_ I understand that my doctor may need x-rays in order to diagnosis my condition and I give permission of all needed diagnostic tests.

\_\_\_\_\_ I understand that my condition may require my doctor to take x-rays to further diagnosis my symptoms. I choose not to have any x-rays at this time and release my doctor of all liabilities. If treatment does not improve, we will take x-rays to further evaluate the problem.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FEMALES ONLY:**

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

I have been advised that the ten (10) days following onset of a menstrual period are generally considered to be safe for x-ray exams.

With those factors in mind, I am advising my doctor that:

I am pregnant \_\_\_\_\_ yes \_\_\_\_\_ no \_\_\_\_\_ don't know

I could be pregnant \_\_\_\_\_ yes \_\_\_\_\_ no \_\_\_\_\_ don't know

My menstrual period is late \_\_\_\_\_ yes \_\_\_\_\_ no \_\_\_\_\_ don't know

I have an IUD \_\_\_\_\_ yes \_\_\_\_\_ no

I have had a tubal ligation \_\_\_\_\_ yes \_\_\_\_\_ no

I have had a hysterectomy \_\_\_\_\_ yes \_\_\_\_\_ no

I have irregular menstrual periods \_\_\_\_\_ yes \_\_\_\_\_ no

My last menstrual period began \_\_\_\_\_

I have begun menopause \_\_\_\_\_ yes \_\_\_\_\_ no

With full understanding of the above, and believing that I am not currently at risk, I wish to have an x-ray examination performed today if requested by my doctor.

Signature: \_\_\_\_\_



**PATIENT RECORD OF DISCLOSURES:**

In general, the HIPPA Privacy rule gives Individuals the Right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communications of PHI be made by alternative means, such as sending correspondence in the individual's office instead of individuals home.

**I wish to be contacted in the following manner (Check all that Applies):**

- Home Telephone: \_\_\_\_\_  Written Communication
- O.K. to leave message with detailed information  O.K. to mail to home address
- Leave message with call-back number **ONLY**  O.K. to mail to my work/office address
- O.K. to fax to this number \_\_\_\_\_  Work Telephone \_\_\_\_\_
- O.K. to leave message with call-back number **ONLY** at work

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Below this line for office use only:**

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for the PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply in uses or disclosures made pursuant to an authorization request by the individual. Healthcare entities must keep records PHI disclosures. Information provided below, if completed properly will constitute an adequate record. Note: Use and disclosures for TPO may be permitted with prior consent in an emergency.

**Record of disclosures of Protected Health Information:**

Date:	Disclosure to whom:	(1)	Description of Disclosure/Purpose of Disclosure:	By Whom Disclosure:	(2)	(3)

- (1) Check this box if the disclosure is authorized
- (2) Type Key: T- Treatment Record: P – Payment Information: O – Healthcare Operations
- (3) Enter how disclosure was made: F – Fax: P – Phone: M – Mail: O - Other



Financial Policy Accidents

Auto Accident/Personal Injury:

Payment Procedures:

You are fully responsible for all services rendered to you regardless of how the Insurance Company or Attorney settlement outcome is. We DO NOT accept assignment on these claims, which means they should pay you directly. It is our policy that you write us a check for the balance due in full on the day of your Release. We will not deposit this check for 10 days, however, on the 11<sup>th</sup> day we will deposit the check unless we have heard from you letting us know that you will be here that day to trade the insurance check with us for your check that we have.

BY SIGNING THIS DOCUMENT, I AM TAKING FULL RESPONSIBILITY FOR PAYMENT OF SERVICES RENDERED TO ME BY CAROLINA HEALTH INNOVATIONS.

I agree that if I do not abide by this Financial Policy as stated above, my account will be turned over to a collection agency at my expense.

All information that I have provided to Carolina Health Innovations dealing with my case history and insurance is correct.

Patient signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_