Health Care Chiropractic Centre

CONFIDENTIAL CHIROPRACTIC NO-FAULT INTAKE FORM

Date: ___ /___ /_____

First Name_____ MI____ Last Name_____ Date of Birth_____

Address_____ City_____ State_____ ZIP_____

Social Security #_____ Martial Status (S) (M) (W) (D) Spouse_____

Contact: Home _____Cell _____Work _____Cell Carrier_____

Personal Email_____ Work Email_____

Contact Preference: Home [ ] Cell [ ] Work [ ] Emergency Contact_____ Phone_____

Occupation_____ Employer_____

Employer Address_____

Whom may we thank for referring you to our office? _____

Past History: Have you… If yes, please list the date and the name of the treating provider.

Been hospitalized in the last five years? Yes [ ] No [ ] _____

Do you smoke? Yes [ ] No [ ] How often? _____
Do you drink alcohol? Yes [ ] No [ ] How often? _____
Do you drink caffeine? Yes [ ] No [ ] How often? _____
Do you exercise? Yes [ ] No [ ] How often? _____

Medications:

List any medications you are currently taking, the dosage amount, and how frequently you take them.

Please include all non-prescription and over the counter vitamins, herbs, minerals, etc.

_____

_____

Allergies:

List any allergies and reactions you have if applicable:

_____

_____

Surgeries:

List any surgeries you've had, the date the surgery was performed, and the treating provider:

_____

Medical History:

List all your past medical history conditions:

_____

_____

List all your family's medical history conditions:

_____

_____

Please answer each question thoroughly about your accident:

Date of accident: ___ /___ /_____ What time did the accident occur? _____

Describe your accident in detail:

_____

_____

_____

Driving Role: [ ] Driver [ ] Passenger in the front [ ] Passenger behind the driver

[ ] Passenger behind the front seat passenger

If you were the driver, were you gripping the steering wheel? [ ] Yes [ ] No

Were you aware the collision was to take place? [ ] Yes [ ] No

Were you unconscious? [ ] Yes [ ] No

Car Type: Yours _____ Theirs _____

How fast were you going? _____ MPH How fast was the other vehicle going? _____MPH

Road Conditions: [ ] Wet [ ] Dry [ ] Icy [ ] Snow

Visibility: [ ] Excellent [ ] Fair [ ] Good [ ] Poor

Were you wearing seatbelts? [ ] Yes [ ] No Were you looking straight ahead? [ ] Yes [ ] No

Headrest Position: [ ] Low [ ] Middle [ ] High

Did any part of your body make contact with the car? [ ] Yes [ ] No

If yes, where? _____

Were paramedics called? [ ] Yes [ ] No

Were you taken to the hospital? [ ] Yes [ ] No

If yes, which hospital? _____

How long were you admitted? _____

If no, did you seek medical attention elsewhere? [ ] Yes [ ] No

If yes, which doctor(s) did you see and when did you see them?

_____

_____

Have you seen any improvement under their care? [ ] Yes [ ] No

Have you been released from their care? [ ] Yes [ ] No

Since the accident have you missed any work and or school? [ ] Yes [ ] No

If yes, how many days have you missed? _____

Has the injury from your accident affected your ability to perform at your job? [ ] Yes [ ] No

Describe your normal routine at work: _____

Has the injury from your accident made it more difficulty to perform tasks at home or socially? [ ] Yes [ ] No

Have you had any automobile accidents in the past? [ ] Yes [ ] No

If yes, please state what date(s) and briefly describe:

_____

_____

Please answer the following in relation to the problem(s) you are currently experiencing:

Complaint I:

Where are you experiencing pain? _____

When did the pain occur? _____

What caused this pain? If you are unsure, please state so.

_____

Have you experienced similar pain in the past? [ ] Yes [ ] No

If so, please state how long ago you've experienced this pain before:

_____

What is the intensity of your pain?

[ ] Mild [ ] Moderate [ ] Severe

[ ] Mild to Moderate [ ] Moderate to Severe

Please rate the pain from 1-10 (1 = little pain | 10 = excruciating pain) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

Describe the nature of your pain:

[ ] Sharp [ ] Dull [ ] Numb [ ] Burning [ ] Shooting [ ] Tingling [ ] Tightness

[ ] Stabbing [ ] Throbbing [ ] Radiating Pain. Where is the pain radiating into?

_____

[ ] Other, please describe:

_____

How frequently do you experience this pain?

[ ] Constantly (76-100% of the day) [ ] Frequently (51-75% of the day)

[ ] Occasionally (26-50% of the day) [ ] Intermittently (0-25% of the day)

What makes the pain worse? _____

What makes the pain better? _____

Complaint II:

Where are you experiencing pain? _____

When did the pain occur? _____

What caused this pain? If you are unsure, please state so.

_____

Have you experienced similar pain in the past? [ ] Yes [ ] No

If so, please state how long ago you've experienced this pain before:

_____

What is the intensity of your pain?

[ ] Mild [ ] Moderate [ ] Severe

[ ] Mild to Moderate [ ] Moderate to Severe

Please rate the pain from 1-10 (1 = little pain | 10 = excruciating pain) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

Describe the nature of your pain:

[ ] Sharp [ ] Dull [ ] Numb [ ] Burning [ ] Shooting [ ] Tingling [ ] Tightness

[ ] Stabbing [ ] Throbbing [ ] Radiating Pain. Where is the pain radiating into? _____
[ ] Other, please describe:
_____
How frequently do you experience this pain?
[ ] Constantly (76-100% of the day) [ ] Frequently (51-75% of the day)
[ ] Occasionally (26-50% of the day) [ ] Intermittently (0-25% of the day)
What makes the pain worse? _____
What makes the pain better? _____

Complaint III:
Where are you experiencing pain? _____
When did the pain occur? _____
What caused this pain? If you are unsure, please state so.
_____
Have you experienced similar pain in the past? [ ] Yes [ ] No
If so, please state how long ago you've experienced this pain before:
_____
What is the intensity of your pain?
[ ] Mild [ ] Moderate [ ] Severe
[ ] Mild to Moderate [ ] Moderate to Severe
Please rate the pain from 1-10 (1 = little pain | 10 = excruciating pain) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
Describe the nature of your pain:
[ ] Sharp [ ] Dull [ ] Numb [ ] Burning [ ] Shooting [ ] Tingling [ ] Tightness
[ ] Stabbing [ ] Throbbing [ ] Radiating Pain. Where is the pain radiating into? _____
[ ] Other, please describe:
_____
How frequently do you experience this pain?
[ ] Constantly (76-100% of the day) [ ] Frequently (51-75% of the day)
[ ] Occasionally (26-50% of the day) [ ] Intermittently (0-25% of the day)
What makes the pain worse? _____
What makes the pain better? _____

Please answer the following regarding your medical coverage:

Who is your insurance carrier for this claim? _____

What is your policy number? _____

What is your claim number? _____

What is the medical billing address for this claim (if you have it)?

_____

_____

Have you retained an attorney? [ ] Yes [ ] No

If yes, what is your attorney's name? _____

What is their contact number? _____

What is their address? _____

_____

Please carefully read below and sign.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

_____ ___ /___ /_____

Patient Signature Date

_____

Parent/Guardian's Signature

If patient is under 18 years of age