Personal Injury Intake Form and Chiropractic Care Agreement

Patient Information:

Today's Date ______________________
Name ___________________________
I prefer to be called________________
Address _________________________
____
____
Sex ☐ **Male** ☐ **Female**
Occupation _______________________
Employer _________________________

Home Phone _______________________
Cell Phone ________________________
Work Phone________________________
Email ____________________________
Date of Birth _____________Age__________
Height ____'_____" Weight ______lbs
Marital Status______________________
No. of Children_____________________
Do you agree to receiving appointment reminders via text message and email?
☐ **YES** ☐ **NO**

If minor, name of parent or guardian ____
Who should we contact in case of an emergency? _______________________________
Relation ___________________________ Phone _______________________________
Address ____

Attorney ___________________________ Phone _______________________________

Primary Care Physician _______________ Phone _______________________________

Were you referred to us by a treating physician? ☐ **YES** ☐ **NO** If yes, who? ___________________
Have you ever been to a chiropractor before? ☐ **YES** ☐ **NO**
Do you have any prior injuries relating to any pending litigations or proceedings? **YES** ☐ **NO**
If yes, please describe? ____
____

Primary Health Insurance: If you have, please provide card to front desk.

Secondary Health Insurance: If you have, please provide card to front desk.

Auto Insurance: Please provide card to front desk.

Auto Insurance Company ______________________________
Auto Policy Number ______________________________
Medical (PIP) Adjustor's Name ______________________________
Medical (PIP Adjustor's Phone Number ______________________________
Claim # ______________________________
Medical (PIP) Claims Mailing Address ______________________________
____

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Accident Information:

Date ____________ Time _______ AM PM Was it reported to the police? ☐ **YES** ☐ **NO**
Was a traffic violation issued? ☐ **YES** ☐ **NO** To whom? ______________________________
Location of accident (Street, Town) ___________________________ # of other passengers _______
Were there other witnesses? ☐ **YES** ☐ **NO** Make/model of vehicle you were in ______________
Please explain in detail how the accident occurred ____
_
Please list symptoms felt immediately after the accident ______________________________________
_
In which direction were you headed? ☐ **N** ☐ **S** ☐ **E** ☐ **W** Approx. speed of vehicle ____MPH
Did the impact to your vehicle come from the: ☐ **FRONT** ☐ **REAR** ☐ **RIGHT** ☐ **LEFT** ☐ **OTHER**
During impact were you facing: ☐ **RIGHT** ☐ **LEFT** ☐ **FORWARD**
Were you ☐ **AWARE** or ☐ **SURPRISED** by the impact?
Were you the ☐ **DRIVER** ☐ **FRONT SEAT PASSENGER** ☐ **BACK SEAT PASSENGER**?
Were you wearing a seat belt? ☐ **SHOULDER HARNESS** ☐ **LAP HARNESS**
Was the vehicle equipped with air bags? ☐ **YES** ☐ **NO** Did they inflate? ☐ **YES** ☐ **NO**
In relation to the base of your skull, where was the headrest? ☐ **ABOVE** ☐ **BELOW** ☐ **AT BASE**
What did your vehicle impact? ☐ **ANOTHER VEHICLE** ☐ **OTHER** ____________________________
If another vehicle, what was the make/model? _____________ Direction _______Speed _______MPH
Did any part of your body strike anything in the vehicle? ☐ **YES** ☐ **NO** Describe ________________
Did the accident render you unconscious? ☐ **YES** ☐ **NO** If yes, for how long? ___________________

Post-Injury Information:

Have you seen any other doctor(s) since the accident? ☐ **YES** ☐ **NO** Name ____________________
When did you go? ☐ **IMMEDIATELY** ☐ **NEXT DAY** ☐ **2 DAYS PLUS**
How did you get there? ☐ **AMBULANCE** ☐ **PRIVATE TRANSPORTATION**
Name of hospital and/or attending doctor: ____
Was he/she a: ☐ **D.C.** ☐ **M.D.** ☐ **D.O.** ☐ **D.D.S.**
Please describe any treatment you received ____
Were X-Rays done? ☐ **YES** ☐ **NO** An MRI? ☐ **YES** ☐ **NO** CAT scan? ☐ **YES** ☐ **NO**
Was medication prescribed? ☐ **YES** ☐ **NO** If yes, what? _________________________________
Have you missed any work since the accident? ☐ **YES** ☐ **NO** Date(s) ________________________

Are your work activities restricted as a result of your injury? ☐ **YES** ☐ **NO**
Indicate the symptoms that are a result of this accident:

☐ **DIZZINESS**	☐ **DIFFICULTY SLEEPING**	☐ **JAW PROBLEMS**	☐ **NAUSEA**
☐ **MEMORY LOSS**	☐ **ARM/SHOULDER PAIN**	☐ **IRRITABILITY**	☐ **BACK PAIN**
☐ **HEADACHE(S)**	☐ **NUMB HANDS/FINGERS**	☐ **FATIGUE**	☐ **LOW BACK PAIN**
☐ **BLURRED VISION**	☐ **TENSION**	☐ **CHEST PAIN**	☐ **BACK STIFFNESS**
☐ **BUZZING IN EAR**	☐ **NECK PAIN**	☐ **SHORT BREATH**	☐ **LEG PAIN**
☐ **EARS RINGING**	☐ **NECK STIFF**	☐ **STOMACH UPSET**	☐ **NUMB FEET/TOES**

☐ **OTHER** ____

Have you ever experienced similar symptoms prior to the accident? ☐ **YES** ☐ **NO**
Has your condition ☐ **IMPROVED** ☐ **WORSENED** or ☐ **STAYED SAME** since the accident?
Is your condition affecting your ☐ **WORK** ☐ **SLEEP** or ☐ **DAILY ROUTINE**? Please explain ______
____
Please indicate your daily job duties and any activities that you are occasionally asked to perform:

☐ **STANDING**	☐ **OPERATING EQUIPMENT**	☐ **DRIVING**	☐ **SITTING**
☐ **TWISTING**	☐ **WORK W/ARMS ABOVE HEAD**	☐ **WALKING**	☐ **CRAWLING**
☐ **TYPING**	☐ **LIFTING**	☐ **BENDING**	☐ **STOOPING**

What positions can you work in with minimum physical effort, and for how long? ________________
Do you work with others who can help you with any heavy lifting? ☐ **YES** ☐ **NO**
While in recovery, are there any light duty tasks you could request? ☐ **YES** ☐ **NO**

Health History

Please check the box for any of the following which apply to you.

☐ **HEART ATTACK or STROKE**	☐ **PACEMAKER**	☐ **MURMUR**
☐ **HEART SURGERY**	☐ **CONGENITAL HEART DEFECT**	☐ **MITRAL VALVE COLLAPSE**
☐ **ARTIFICIAL VALVES**	☐ **ALCOHOL/DRUG ABUSE**	☐ **VENEREAL DISEASE**
☐ **HEPATITIS**	☐ **SHINGLES**	☐ **Cancer**
☐ **FREQUENT NECK PAIN**	☐ **HIV+/AIDS**	☐ **EMPHYSEMA**
☐ **ANEMIA**	☐ **HIGH/LOW BLOOD PRESSURE**	☐ **PSYCHIATRIC PROBLEMS**
☐ **RHEUMATIC FEVER**	☐ **SEVERE/FREQ. HEADACHES**	☐ **KIDNEY PROBLEMS**
☐ **ULCERS/COLONITIS**	☐ **FAINTING/SEIZURE/EPILEPSY**	☐ **SINUS PROBLEMS**
☐ **ASTHMA**	☐ **DIABETES**	☐ **DIFFICULTY BREATHING**
☐ **TUBERCULOSIS**	☐ **LOWER BACK PROBLEMS**	☐ **ARTIFICIAL BONES/JOINTS**
☐ **ARTHRITIS**		

Please list **any other** medical conditions that you have or have ever had. ______________________

Please list any allergies. ____

Please list previous hospitalizations or surgeries and dates. ______________________________

Please list any past motor vehicle accidents or traumas and dates. __________________________

Please list any prescription and over-the-counter medications you are currently taking, including supplements. ____
____
Is there anything else about your health history or family health history that you feel is important to share? ____
Do you exercise? ☐ **YES** ☐ **NO** Are you on a special diet? ☐ **YES** ☐ **NO** Describe: ______________
Do you smoke? ☐ **YES** ☐ **NO** If yes, please circle: cigarettes, e-cigarettes, vape, other tobacco
Are you wearing: ☐ **ORTHOTICS** ☐ **HEEL LIFTS** ☐ **ARCH SUPPORTS**
For women*:* Are you pregnant? ☐ **YES** ☐ **NO** How long? _______ Nursing? ☐ **YES** ☐ **NO**

Patient/Legal Guardian Signature____________________________**Date** ________________

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PATIENT AGREEMENT TO PAY FOR CHIROPRACTIC SERVICES AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize FOX Spine + Sports Medicine, to furnish my insurance carrier **all** information concerning my treatment and/or illness. I also authorize benefits under this claim to be made payable directly to FOX Spine + Sports Medicine. I understand that I am responsible financially to FOX Spine + Sports Medicine for charges not covered by my insurance company, I, the patient or the guardian of the patient, will be responsible in full in payment.

I also understand that all co-payments and / or deductibles are to be paid at the time services are rendered. I agree to assist FOX Spine + Sports Medicine in any collection efforts to receive payment from my insurance company providing the office with any information that may be necessary for the physicians to receive payment.

I understand that by signing this agreement I agree to make all payments to FOX Spine + Sports Medicine that I am responsible for, and that if the insurance denies a claim for any reason that I am responsible ultimately for payment in full to the physicians.

By not signing this agreement, services may be denied.

Signature: ______________________ **Date:** ______________________

Print: ___________________________ **Date:** ______________________

Guardian Signature (if patient is not competent)

Please give the front desk your insurance card and driver's license to be photocopied.
Thank you.

I authorize the release of any medical information necessary to process this claim in FOX Spine + Sports Medicine's discretion. I permit a copy of the authorization to be used in the place of the original.

Signature: ______________________ **Date:** ______________________

I hereby authorize FOX Spine + Sports Medicine to apply for benefits on my behalf for covered services rendered by him/her or by his/her order. I request that payment from my insurance company be made directly to FOX Spine + Sports Medicine (or to the party who accepts the assignment). I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Signature: __________________________ **Date:** ______________________

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FOX SPINE + SPORTS MEDICINE

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

By signing this form, you hereby acknowledge receipt of the **Notice of Privacy Practices**. Our **Notice of Privacy Practices** provides information about how we may use and disclose your protected information. We encourage you to read it in full. **Our Notice of Privacy Practices** is subject to change.

______________________________ ___________________________ _______
Patient Name (please print) Patient Signature Date

______________________________ ___________________________ ________
Parent, Guardian, or Patient's legal representative, if applicable. Please print, sign, and date.

List below the name(s) and relationship of people to whom you authorize Fox Spine + Sports Medicine to release your **Protected Health Information** (PHI).

____________________________ ___________________________
Name(s) Relationship(s)

OFFICE POLICIES

The following are FOX Spine + Sports Medicine's office policies. Please read carefully and be sure to ask any questions you might have before signing the document.

Appointment Scheduling and Cancellation Policy. At FOX Spine + Sports Medicine, we understand that unanticipated events happen occasionally in everyone's life. Business meetings, project deadlines, flight delays, car problems, and illness are just a few reasons why one might consider canceling an appointment. In our desire to be effective and fair to all of our patients and staff **24 hour advance notice is required when canceling an appointment otherwise the full fee for the missed appointment will be charged to your account.** This allows the opportunity for someone else to utilize our services during that appointment time.

Office Visits. We understand that the undersigned and/or the Patient may come to the office with family, friends or others. The Patient (or, if a minor, the undersigned) acknowledges that the Patient (or undersigned) is solely responsible for children or those in their care. This is an office; we are busy with patients. Please be careful and aware of your surroundings.

Telephone Messages. We do not leave detailed messages on voicemails or answering machines, unless you consent to the same in writing.

Patient or Legal Guardian Signature________________________________Date _______

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CHIROPRACTIC INFORMED CONSENT

The undersigned Patient (which includes the parent/guardian) understands and acknowledges that the Patient is only receiving chiropractic care from FOX Spine + Sports Medicine, its doctors and staff, (jointly, "FOX Spine + Sports Medicine").

The Doctors are "chiropractic physician" as defined in Florida Statute 460.403(5)(2008). Chiropractic physicians examine, analyze, and diagnose the human living body and its diseases by use of (a) any physical, chemical, electrical or thermal methods, (b) x-ray for diagnosing, (c) blood tests, and (d) other chiropractic methods.

Before you, the Patient, receive chiropractic care, it is important that you read this Consent and understand the nature and risks of chiropractic medicine. The "practice of chiropractic medicine" (or chiropractic care) involves the adjustment, manipulation, and treatment of your body in which vertebral subluxations and other malpositioned articulations and structures may be interfering with the normal generation, transmission, and expression of nerve impulse between the brain, organs, and tissue cells, thereby causing disease. Chiropractic adjustments, manipulations, and treatments are intended to restore the normal flow of nerve impulse which produces normal function and consequent health.

The undersigned Patient understands and acknowledges that there are risks associated with the practice of chiropractic medicine and chiropractic care including but not limited to ataxia, bruising, thermal injuries, dislocations/subluxations, dizziness, "drop attacks," fracture(s), mobility disruption, paralysis, quadriplegia, spinal injury, stroke/disruption of blood flow to brain, vision problems, and death.

The Patient is encouraged to ask questions! Although we are not affiliated with and cannot confirm the content of internet sites, resources such as WebMD, Chiro.org, AmerChiro.org, and others may be helpful. The Patient is specifically instructed to consult a medical doctor before receiving (and during/after) chiropractic medicine.

I the undersigned, understand the risks and limitations associated with the practice of chiropractic medicine, including the use of chiropractic care, evaluation, diagnosis, adjustments, manipulations, and treatments by FOX Spine + Sports Medicine. Having read this form and having asked and having had answered any questions I might have about my condition and treatments, and as a result having fully understood the services to be provided by FOX Spine + Sports Medicine and what I should expect from my treatment, including the risks associated therewith. I hereby give my informed consent to receive chiropractic medicine from FOX Spine + Sports Medicine.

Patient or Legal Guardian Signature_________________________________**Date** _______

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