**New Patient Intake Form**

**PLEASE HAVE YOUR DRIVERS LICENSE AND AUTO INSURANCE CARD AVAILABLE THANK YOU**

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| **Patient Information** |

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_Date of Accident\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City/State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_

Best Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email Address (for clinic news)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Marital Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Company Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse/Gaurdian’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Name, In Case of Emergency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Your Auto Insurance** |

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MedPay Claim #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adjustor’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **At-Fault Auto Insurance** |

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Claim #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adjustor’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Attorney Information** |

Attorney’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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| **Assignment of Benefits and Release of Records** |

I authorize my primary auto insurance company or tertiary auto insurance company to make payments to Denver Chiropractic, LLC, Antero Medical Group, PC and Physical Rehabilitation Specialists, PC for all services provided by Denver Chiropractic, LLC, Antero Medical Group, PC and Physical Rehabilitation Specialists, PC. I give permission for my doctors and any holder of my medical records to be released by Denver Chiropractic, LLC, Antero Medical Group, PC and Physical Rehabilitation Specialists, PC. I will provide all information needed to process my claims in a timely manner.

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| **Consent to Examination & Treatment** |

I, the patient named below, hereby request and consent to the performance of chiropractic examinations, adjustments, dry needling, Graston technique, active release technique, flexion-distraction therapy, moist heat, electrotherapy, ultrasound, kinesio taping, and other procedures on me (or the patient named below, for whom I am legally responsible) by the licensed doctors at Denver Chiropractic, LLC. I understand and I am informed that, in the practice of chiropractic there are some risks to examination and treatment including, but not limited to, soreness, fractures, disc injuries, strokes, dislocations, sprains, pneumothorax, increased symptoms, or no improvement. 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 on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. I intend this consent form to cover the entire course of treatment of my present condition and for any future conditions for which I seek treatment. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.

I also consent to have Antero Medical Group, PC and their employees to evaluate and treat the patient named below for medical complaints and illnesses. This includes taking of medical information, evaluation by physical examination, obtaining bodily fluids for laboratory testing, obtaining of X-rays for diagnosis, the administration of medications for treatment, and any other treatment or evaluation that may be necessary. If at any time, I do not wish to have these services rendered, I may state so and they will not be provided. All of my information will remain confidential. I acknowledge I have been offered a copy of Antero Medical Group, PC’s Notice of Privacy Practice. I hereby consent to evaluation and treatment by Physical Rehabilitation Specialists, PC and/or its clinical staff for either my

I hereby consent to evaluation and treatment by Physical Rehabilitation Specialists, PC and/or its clinical staff for either my

dependent or myself. I understand there are certain risks associated with any examination and treatment and those risks have

been presented and explained to me.

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| **Our Privacy Policy** |

The office of Denver Chiropractic, LLC, Antero Medical Group, PC and Physical Rehabilitation Specialists, PC is committed to upholding the security and confidentiality of personal information that you provide to us. We take our responsibility of safeguarding your information very seriously. We do not share or sell patient information with anyone outside our office without your written consent. This policy covers information including personal, financial, or health information about a consumer or customer relationship. I hereby authorize that my records of evaluation and treatment with the office of Denver Chiropractic, LLC may be forwarded to referring physicians, specialists, or therapists who are also involved in my healthcare.

**I understand and have read the assignment of benefits and release of records, the consent to examination and treatment and our privacy policy**

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

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| **Release of Medical Information** |

1. I give permission for Antero Medical Group, PC, Denver Chiropractic LLC and Physical Rehabilitation Specialists, PC to release information, verbal or written, contained in my medical record, and other related information to my insurance company, attorney, employer, school, related healthcare provider, assignee and/or beneficiaries and all other related personas as it relates to my treatment.

2. I authorize Antero Medical Group, PC, Denver Chiropractic, LLC and Physical Rehabilitation Specialists, PC to obtain medical records and/or professional information from my physician or other medical professional, attorney and insurance company as it relates to my treatment and claim.

3. If you have never been adjusted you may be sore after your treatment. This soreness is similar to a long hike or a good workout type of soreness. Soreness can be a good response, as is the soreness you get after a good workout.

**I understand and have read the consent to treatment and examination, our privacy policy, and information regarding your healing.**

 **Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_**

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| **Consent for Release of Information** |

By checking this box, I agree to be contacted and that voicemail may be left on my phone by an Antero Medical Group, PC, Denver Chiropractic, LLC and Physical Rehabilitation Specialists, PC, patient liason or Physician.

CONSENT FOR THE TRANSMISSION OF INFORMATION: By checking this box, I give Antero Medical Group, PC, Denver Chiropractic, LLC and Physical Rehabilitation Specialists, PC, permission to communicate any future medical information to me by the telephone and/or email provided earlier in this document.

By signing below, I understand this agreement to be between Antero Medical Group, PC, Denver Chiropractic, LLC and Physical Rehabilitation Specialists, PC, AND THE UNDERSIGNED.

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| **History of Accident** |

1. Location of Accident City/State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Street/s\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Approx. Time of Day\_\_\_\_\_\_\_\_\_\_\_\_ Weather Conditions?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Seat Belt On?\_\_\_\_\_\_\_\_

3. Any Passengers?\_\_\_\_\_\_\_\_Names\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Year/Make/Model of Your Vehicle \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Vehicle\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Your Approx. Speed at Impact? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Vehicle\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Your Head Position at Impact? (turned L/R, up/down)\_\_\_\_\_ Were You Aware of Impending Impact?\_\_\_

7. Drivers Feet Position at Impact? (brake, clutch, both, gas, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Witness Names? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Were Photographs Taken? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. What Part of Your Car Was Damaged? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Car?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 9. Description of the Accident 10. Diagram of the accident

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

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\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

11. Estimate for repair of your car\_\_\_\_\_\_\_\_\_\_\_\_\_

12. Did either insurance company refer you to the place where you got the estimate?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. Were you paid for the vehicle damage?\_\_\_\_\_\_\_\_How much?\_\_\_\_\_\_\_\_\_\_

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| **Regarding Your Healing** |

1. Auto injuries produce wide spread damage and thus take more visits then an average case of non-auto related acute neck or back pain. On average, a typical whiplash injury will require approximately 26 visits for resolution of the injuries. Everyone responds to treatment slightly different which may shorten or lengthen the amount of total visits needed.

2. Neck or back pain usually fluctuates, meaning that you will have flare ups along the course of your healing. It is expected to have aggravations of your injuries.

3. If you have never been adjusted you may be sore after your treatment. This soreness is similar to a long hike or a good workout type of soreness. Soreness can be a good response, as is the soreness you get after a good workout.

**I understand and have read the release of medical information, consent for doctor-patient communications, and information regarding your healing.**

 **Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_**

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| **History of Accident** |

1. Location of Accident City/State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Street/s\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Approx. Time of Day\_\_\_\_\_\_\_\_\_\_\_\_\_\_Weather Conditions?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Seat Belt On?\_\_\_\_\_\_\_\_\_\_

3. Any Passengers?\_\_\_\_\_\_\_\_Names\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Year/Make/Model of Your Vehicle\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other Vehicle\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Your Approx. Speed at Impact?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other Vehicle\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Your Head Position at Impact?(turned L/R, up/down)\_\_\_\_\_\_\_\_\_\_\_\_You Aware of Impending Impact?\_\_\_\_\_

7. Drivers Feet Position at Impact? (brake, clutch, both, gas, etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Witness Names?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Photographs Taken?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. What Part of Your Car Was Damaged?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Their’s\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 9. Description of the Accident 10. Diagram of the accident

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11. Cost of Repairing Your Car\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. Did either insurance company refer you to the place where you got the estimate?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. Were you paid for the vehicle damage?\_\_\_\_\_\_\_\_How much?\_\_\_\_\_\_\_\_\_\_



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| **Injuries, Impairments, & Damages**  |

Please mark any of the symptoms you have experienced SINCE the accident

|  |  |  |
| --- | --- | --- |
| \_\_Headaches | \_\_Dizziness | \_\_Difficulty Concentrating |
| \_\_Long Term Memory Loss | \_\_Short Term Memory Loss | \_\_Amnesia |
| \_\_Loss of Consciousness at Scene | \_\_“Blackouts” Since Collision | \_\_Forgetting ATM or other Numbers |
| \_\_Reading Problems | \_\_Writing Problems | \_\_Typing Problems |
| \_\_Apathy | \_\_Irritability | \_\_Sleep Disturbances |
| \_\_Personality Changes | \_\_Emotional Difficulties | \_\_Relationship Difficulties |
| \_\_Blurred Vision | \_\_Photophobia (Sensitivity to Light) | \_\_Vision Changes |
| \_\_Intolerance to Alcohol | \_\_Intolerance to Heat | \_\_Intolerance to Cold |
| \_\_Impaired Comprehension | \_\_Impaired Learning | \_\_Attention Impairment |
| \_\_Loss of Libido | \_\_Missing Periods of Time | \_\_Speech Difficulties |
| \_\_Concussion in Collision | \_\_Nausea | \_\_Vomiting |
| \_\_Extreme Thirst Since Collision | \_\_Fatigue | \_\_Menstrual Irregularities |
| \_\_Tinnitus (Ringing of Ears) | \_\_Noise Intolerance | \_\_Loss of Coordination |
| \_\_Bumping Into Objects in View | \_\_Loss of Balance | \_\_Fluid in Ears |
| \_\_Hearing Loss | \_\_Vertigo (Spinning Sensation) | \_\_Increased Symptoms in Crowds |
| \_\_Anxiety | \_\_Depression | \_\_Change in Personality |
| \_\_Flashbacks to Accident Scene | \_\_Intrusive Thoughts of Accident | \_\_Nightmares Since Collision |
| \_\_Unusual Behavior Since Collision | \_\_Social Withdrawal | \_\_Panic Attacks |
| \_\_Thoughts of Death /Suicide | \_\_Weight Loss / Gain \_\_\_\_\_lbs | \_\_Loss of Taste / Smell |
| \_\_Blackouts with Neck Movements | \_\_Dizziness with Neck Movements | \_\_“Clunk” Sound w/ Moving Neck |
| \_\_Jaw Pain | \_\_Clicking in Jaw | \_\_Pain with Chewing |

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| --- | --- | --- | --- | --- | --- |
| Numbness / tingling / weakness in arms? | Yes | No | R |  L | Level(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Numbness / tingling / weakness in legs? | Yes | No | R |  L | Level(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Did the Seatbelt bruise you? \_\_\_\_\_\_\_Where? \_\_\_\_\_\_\_\_ |  |  |
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| **Injuries, Impairments, & Damages Cont.** |

Where was headrest located before impact? \_\_Upper Back \_\_Mid Neck \_\_Mid Head \_\_Upper Head \_\_None

|  |  |
| --- | --- |
| Did your head or body strike anything inside the car? \_\_Yes | \_\_ No (If yes, what?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Were any of your items displaced? \_\_Yes | \_\_ No (If yes, what?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Did you lose consciousness? \_\_Yes | \_\_No | If Yes (approximate length of time) \_\_\_\_\_\_\_\_\_\_\_ |
| Did your Airbag(s) Deploy? \_\_Yes | \_\_No | Did your seats break? \_\_Yes \_\_No  |   |

Were you transported via EMS or Ambulance? \_\_\_ Yes \_\_\_ No (If yes, please provide)

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Ambulance Company |  Date | From | To |

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any Emergency Room, Hospitalizations, Outpatient Surgeries (Related only to this Collision):

 Physician Facility Surgery / Problem

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any Treating Physicians / Specialists / Therapists (Related only to this Collision):

 Provider Facility Address Phone

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything you are currently unable to do, that you were able to do prior to the accident?

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| **Injuries, Impairments, & Damages Cont.** |

**Impaired Activities**

Circle all activities which have been impaired in any way by the accident in question:

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| --- | --- | --- | --- | --- |
| *Daily Activities* |   |   |   |   |
| bathing/showering | bending | brushing teeth |  Dressing | driving car |
| vacationing | dining out | movie going |  standing | sitting |
| sexual relations | lifting | church events |  child care | Religious (bending/kneeling) |
| washing hair | eating | Moving |  reading | shaving |
| shopping | watching TV | sleeping |  traveling | social events |
| *Domestic Activities (Activities within the Home)* |   |   |
| Bending | Cooking | ironing | housecleaning | laundry |
| Washing Dishes | vacuuming | dusting | interior painting | decorating |
| *Household Activities (Activities outside the Home)* |   |   |
| Trimming bushes | Gardening | Tree trimming Mowing Lawn | Yard Work |
| Exterior painting | Car Washing | Landscaping | House Maintenance | Farm activities |
| *Work Activities* |   |   |   |   |
| Sitting | standing | lifting | using telephone | computer work |
| Reading | bending | typing | writing | child care |
| *Hobby Activities* |   |   |   |   |
| Aerobic exercise | archery | backpacking | bowling | badminton |
| baseball | basketball | basketry | bicycling | Boxing |
| card playing | camping | dancing | fencing | Fishing |
| flying | football | gardening | golf | Handball |
| gymnastics | health clubs | hockey | hunting | Judo |
| horseback riding | ice skating | Karate | painting | Yoga |
| jogging/running | photography | raquetball | rafting | sailing |
| mountain climbing | sewing | snow skiing | swimming | walking |
| musical instruments | volleyball | water skiing | water sports | weight lifting |

Activities which you have performed despite pain, due to financial, family or personal needs (Duties Under Duress):

\_\_Work \_\_Education \_\_Domestic (Activities within the Home) \_\_Household (Duties outside the Home)

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

Past Motor Vehicle Accidents, Workers Compensation Claims, or other claims of Any Sort:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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| **Injuries, Impairments, & Damages Cont.** |

**Describe your Headache pain:** \_\_\_ Sharp \_\_\_ Dull \_\_\_ Aching \_\_\_ Stabbing \_\_\_ Cramping

**Are your symptoms (please check):**  \_\_\_\_\_Constant \_\_\_\_Come and go

**Onset: Did the headaches start?** \_\_\_ Before accident \_\_\_ At time of accident \_\_\_After accident

**How severe are your headaches on a scale of 1 to 10? \_\_\_\_\_**

**What makes your headaches worse?** \_\_Washing \_\_Dressing \_\_Grooming \_\_Lifting \_\_ Sitting \_\_Standing

**Describe your Neck pain:** \_\_\_ Sharp \_\_\_ Dull \_\_\_ Aching \_\_\_ Stabbing \_\_\_ Cramping

**Are your symptoms (please check):**  \_\_\_\_\_Constant \_\_\_\_Come and go

**Onset: Did the headaches start?** \_\_\_ Before accident \_\_\_ At time of accident \_\_\_After accident

**How severe are your neck pain on a scale of 1 to 10? \_\_\_\_\_**

**What makes your neck pain worse?** \_\_Washing \_\_Dressing \_\_Grooming \_\_Lifting \_\_ Sitting \_\_Standing

**Do you experience any numbness, tingling or weakness into your arms?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe your Back pain:** \_\_\_ Sharp \_\_\_ Dull \_\_\_ Aching \_\_\_ Stabbing \_\_\_ Cramping

**Are your symptoms (please check):**  \_\_\_\_\_Constant \_\_\_\_Come and go

**Onset: Did the back pain start?** \_\_\_ Before accident \_\_\_ At time of accident \_\_\_After accident

**How severe is your back pain on a scale of 1 to 10? \_\_\_\_\_**

**What makes your back pain worse?** \_\_Washing \_\_Dressing \_\_Grooming \_\_Lifting \_\_ Sitting \_\_Standing

**Do you experience any numbness, tingling or weakness into your legs?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe your Extremity pain:** \_\_\_ Sharp \_\_\_ Dull \_\_\_ Aching \_\_\_ Stabbing \_\_\_ Cramping

**Are your symptoms (please check):**  \_\_\_\_\_Constant \_\_\_\_Come and go

**Onset: Did the extremity pain start?** \_\_\_ Before accident \_\_\_ At time of accident \_\_\_After accident

**How severe are your extremity pain on a scale of 1 to 10? \_\_\_\_\_**

**What makes your extremity pain worse?** \_\_Washing \_\_Dressing \_\_Grooming \_\_Lifting \_\_ Sitting \_\_Standing

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| **Injuries, Impairments, & Damages Cont.** |

**Describe any cognitive issues you are having and give life examples where appropriate:**

**Forgetfulness:** \_\_\_ Yes \_\_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Confusion:** \_\_\_ Yes \_\_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Anxiety:** \_\_\_ Yes \_\_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sadness:** \_\_\_ Yes \_\_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Anger:** \_\_\_ Yes \_\_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sleep Disturbance:** \_\_\_ Yes \_\_\_No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Suicidal thoughts:** \_\_\_ Yes \_\_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Homicidal thoughts:** \_\_\_ Yes \_\_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List any medical problems you have:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had any major surgeries?** \_\_\_ Yes \_\_\_No (if yes please list surgery and approximate date(s)

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

**List any medications you are currently taking:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Do you have any drug allergies?** \_\_\_ Yes \_\_\_No (if yes please list)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have severe illness in your family? (Heart disease, blood clot, diabetes, etc..)** \_\_\_ Yes \_\_\_No

**Please List:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you: use tobacco?** \_\_\_ Yes\_\_\_No -- **Alcohol?** \_\_\_ Yes \_\_\_No -- **Illicit Drugs?**\_\_\_ Yes \_\_\_No

**Are you currently working?** \_\_\_ Yes \_\_\_No **What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Female patients:***

**Could you be pregnant?** \_\_\_ Yes \_\_\_No – **Are you breast feeding**? \_\_\_ Yes \_\_\_No

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| **Injuries, Impairments, & Damages Cont.** |

**\*Mark the areas on the diagram where you feel pain\***

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**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\* OFFICE USE ONLY \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

***Vitals: T\_\_\_\_\_\_ BP\_\_\_\_\_\_/\_\_\_\_\_\_ P\_\_\_\_\_\_\_ SaO2\_\_\_\_\_\_***

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| --- |
| **Denver Chiropractic, LLC Lien** |

TO: Denver Chiropractic, LLC

FROM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Print Patient Name)

I hereby authorize and direct my attorney/tertiary insurance company, to pay directly to said health provider such sums as may be due and owing it for medical services rendered me by reason of my accident on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(date of accident) and to withhold such sums from the net proceeds of any settlement, judgment or verdict as may be necessary to adequately protect said health provider. Net proceeds means the gross amount recovered, less any attorney fees and costs. In exchange for receiving this lien, said health provider agrees to forego further collection efforts. I hereby further give a lien on my case to said health provider against any and all net proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. This lien shall be irrevocable and shall be valid and enforceable out of the net proceeds of my settlement, judgment or verdict. I understand that if I discharge my attorney, I have an obligation to notify said health care provider in writing within 48 hours.

Please initial all statements below:

\_\_\_\_\_ I understand that I will be charged the full usual and customary prices for my medical care and not cash pay or insurance rates. I further understand that this is the amount I am expected to repay the provider. I further agree that this amount is reasonable.

\_\_\_\_\_ I agree that if, at any time, including prior to settlement, the provider finds it necessary to proceed against the patient to collect medical bills, the provider may do so.

\_\_\_\_\_ In the event of the receipt of funds and non-payment resulting in the institution of lien enforcement proceedings, I shall be responsible for the payment of all reasonable fees and costs, including attorney’s fees incurred by my medical providers in enforcing said lien.

\_\_\_\_\_ I fully understand that I am directly and fully responsible to said health provider for all medical bills submitted for services rendered me and that this agreement is made solely for said health provider’s additional protection and in consideration of awaiting payment.

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

 Date [PATIENT NAME]

We, the health provider, agree to the terms stated above.

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

By: Denver Chiropractic, LLC, / Owner: Dr. Trent Artichoker

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

 Date