

Motor Vehicle Accident History

PATIENT NAME:		DATE:	
ADDRESS:		CITY:	STATE/ZIP CODE:
HOME PHONE NUMBER:		CELL PHONE NUMBER:	
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	AGE:	GENDER:
EMERGENCY CONTACT NAME:		EMERGENCY CONTACT PHONE NUMBER:	
EMPLOYER NAME:		EMPLOYER ADDRESS:	

ACCIDENT INFORMATION

DATE OF ACCIDENT:	TIME OF ACCIDENT:	WHERE WERE YOU LOCATED IN THE VEHICLE AT THE TIME OF THE ACCIDENT? <input type="checkbox"/> DRIVER <input type="checkbox"/> PASSENGER <input type="checkbox"/> FRONT SEAT <input type="checkbox"/> BACK SEAT	
NUMBER OF PEOPLE IN THE CAR:	NAMES OF PEOPLE IN THE CAR WITH YOU:		
WHAT DIRECTION WAS YOUR CAR HEADED? <input type="checkbox"/> NORTH <input type="checkbox"/> SOUTH <input type="checkbox"/> EAST <input type="checkbox"/> WEST		ON WHAT STREET WERE YOU HEADED?	
WHAT DIRECTION WAS THE OTHER CAR HEADED? <input type="checkbox"/> NORTH <input type="checkbox"/> SOUTH <input type="checkbox"/> EAST <input type="checkbox"/> WEST		WERE YOU STRUCK FROM: <input type="checkbox"/> BEHIND <input type="checkbox"/> FRONT <input type="checkbox"/> LEFT SIDE <input type="checkbox"/> RIGHT SIDE	
WERE YOU KNOCKED UNCONSCIOUS? <input type="checkbox"/> YES <input type="checkbox"/> NO		DID YOU HIT YOUR HEAD? <input type="checkbox"/> YES <input type="checkbox"/> NO	
WHERE WERE YOU TAKEN AFTER THE ACCIDENT?			BY AMBULANCE: <input type="checkbox"/> YES <input type="checkbox"/> NO
WERE THE POLICE ON THE SCENE? <input type="checkbox"/> YES <input type="checkbox"/> NO	WAS A REPORT FILED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOU HAVE A COPY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
HAVE YOU BEEN TREATED BY ANY OTHER DOCTORS FOR THIS ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		SINCE THE INJURY, ARE YOUR SYMPTOMS: <input type="checkbox"/> IMPROVING <input type="checkbox"/> GETTING WORSE <input type="checkbox"/> GETTING BETTER	
HAVE YOU LOST TIME FROM WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE YOU LEFT WORK:	DATE YOU RETURNED TO WORK:
HAVE YOU BEEN INVOLVED IN AN ACCIDENT IN THE PAST? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE DESCRIBE:	
DO YOU HAVE ANY PREVIOUS ILLNESSES WHICH RELATE TO THIS CASE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE DESCRIBE:	
DO YOU HAVE ANY ACTIVITY RESTRICTIONS AS A RESULT OF THIS INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE DESCRIBE:	

INSURANCE INFORMATION

AUTO INSURANCE COMPANY NAME:	
ADJUSTER NAME:	ADJUSTER PHONE NUMBER:
POLICY NUMBER:	CLAIM NUMBER:

What is your chief complaint: _____

When did your symptoms first appear? _____

Is this condition: Getting Worse Stays the Same Comes and Goes Unbearable

Rate the severity of your discomfort on a scale of 0-10, 10 being the most discomfort/severe: 0 1 2 3 4 5 6 7 8 9 10

What type of pain are you experiencing?

Sharp Dull Throbbing Ache Shooting Tingling
Numbness Stiff

Does it interfere with your: Work Sleep Daily Routine

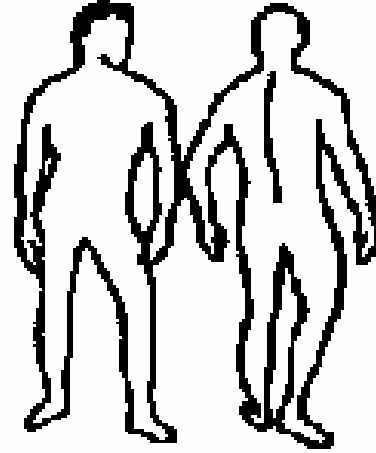
Activities or movements that are difficult to perform:

Sitting Standing Walking Bending Lying Down

Is pain radiating: Y / N. If Yes, Where:

R. Arm L. Arm R. Leg L. Leg

Mark an "X" on the picture where you continue to have discomfort/pain/symptoms



Additional complaint: _____

When did your symptoms first appear? _____

Is this condition: Getting Worse Stays the Same Comes and Goes Unbearable

Rate the severity of your discomfort on a scale of 0-10, 10 being the most discomfort/severe: 0 1 2 3 4 5 6 7 8 9 10

What type of pain are you experiencing?

Sharp Dull Throbbing Ache Shooting Tingling
Numbness Stiff

Does it interfere with your: Work Sleep Daily Routine

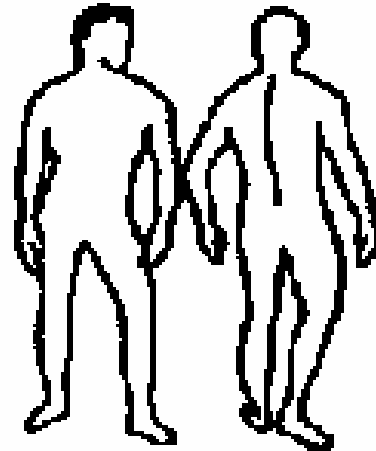
Activities or movements that are difficult to perform:

Sitting Standing Walking Bending Lying Down

Is pain radiating: Y / N. If Yes, Where:

R. Arm L. Arm R. Leg L. Leg

Mark an "X" on the picture where you continue to have discomfort/pain/symptoms



Additional complaint: _____

When did your symptoms first appear? _____

Is this condition: Getting Worse Stays the Same Comes and Goes Unbearable

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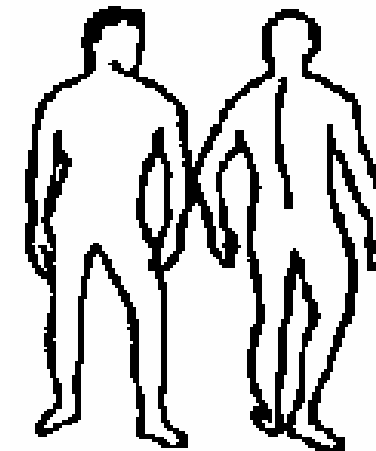
Activities or movements that are difficult to perform:

Sitting Standing Walking Bending Lying Down

Is pain radiating: Y / N. If Yes, Where:

R. Arm L. Arm R. Leg L. Leg

Mark an "X" on the picture where you continue to have discomfort/pain/symptoms



QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____

Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Symptoms-Headache Neck Low Back

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

1 – What is your pain RIGHT NOW?

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

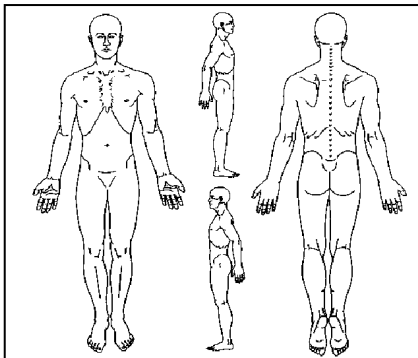
ACCIDENT INFORMATION

DESCRIBE THE ACCIDENT IN YOUR OWN WORDS:

INSTRUCTIONS: *CHECK ANY/ALL SYMPTOMS NOTED AFTER THE ACCIDENT.*

- | | | |
|--|---|---|
| <input type="checkbox"/> HEADACHE | <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> LIGHT BOTHERS EYES |
| <input type="checkbox"/> NECK PAIN | <input type="checkbox"/> HEAD SEEMS HEAVY | <input type="checkbox"/> LOSS OF MEMORY |
| <input type="checkbox"/> NECK STIFFNESS | <input type="checkbox"/> PINS & NEEDLES IN ARMS | <input type="checkbox"/> EARS RING |
| <input type="checkbox"/> SLEEPING PROBLEMS | <input type="checkbox"/> PINS & NEEDLES IN LEGS | <input type="checkbox"/> FACE FLUSHED |
| <input type="checkbox"/> BACK PAIN | <input type="checkbox"/> NUMBNESS IN FINGERS | <input type="checkbox"/> BUZZING IN EARS |
| <input type="checkbox"/> NERVOUSNESS | <input type="checkbox"/> NUMBNESS IN TOES | <input type="checkbox"/> LOSS OF BALANCE |
| <input type="checkbox"/> TENSION | <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> FAINTING |
| <input type="checkbox"/> IRRITABILITY | <input type="checkbox"/> FATIGUE | <input type="checkbox"/> LOSS OF SMELL |
| <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> LOSS OF TASTE |
| <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> FEET FEEL COLD | <input type="checkbox"/> UPSET STOMACH |
| <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> HANDS FEEL COLD | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> FEVER | <input type="checkbox"/> COLD SWEATS | <input type="checkbox"/> OTHER: _____ |

INSTRUCTIONS: *Please mark the area and type of pain on the drawings using the codes listed below:*
N=Numbness P=Pain A=Ache T=Tingling S=Stiffness/Soreness



COMMENTS:

PLEASE PROVIDE ANY OTHER PERTINENT INFORMATION YOU THINK WE SHOULD KNOW:

DOCTOR ONLY

DOCTOR COMMENTS:

SIGNATURE

PATIENT SIGNATURE:

DATE:

Brittian Chiropractic Center

205 S. Stratford Rd, Suite M
Winston Salem, NC 27103

2828 Battleground Avenue, Suite C
Greensboro, NC 27408

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including and not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to anticipate and explain all risks and complications. 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.

By signing below I agree to the above and allow the doctor, affiliated with Brittian Chiropractic Center, PLLC, to perform such. This consent will cover the entire course of my treatment.

Patient Name: _____ Date: _____

Patient or Guardian Signature: _____ Date: _____

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Ownership of X-ray Films: It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.

SIGN IF READ ABOVE _____

DATE _____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):

RELATIONSHIP TO PATIENT:

SIGNATURE:

DATE: