

Patient Basic Information

Automobile Accident Description

<p>Personal Information:</p> <p>First Name: <input style="width:100%;" type="text"/></p> <p>Last Name: <input style="width:100%;" type="text"/></p> <p>Middle Initial: <input style="width:100%;" type="text"/></p> <p>Address:</p> <p>City, State, Zip: <input style="width:100%;" type="text"/></p> <p>Home Phone: <input style="width:100%;" type="text"/> Work Phone: <input style="width:100%;" type="text"/></p> <p>Social Security No: <input style="width:100%;" type="text"/></p> <p>Date of Birth: <input style="width:100%;" type="text"/></p> <p>Date of Injury/Onset: <input style="width:100%;" type="text"/></p>	<p>Your Vehicle Type:</p> <p><input type="radio"/> Car <input type="radio"/> S.U.V. <input type="radio"/> Van <input type="radio"/> Bus <input type="radio"/> Large Truck <input type="radio"/> Pickup Truck</p> <p>Other Type: <input style="width:100%;" type="text"/></p> <p>Your Position in Vehicle</p> <p><input type="radio"/> Driver <input type="radio"/> Front Passenger <input type="radio"/> L.Rear Passenger <input type="radio"/> R.Rear Passenger</p> <p>Other Position: <input style="width:100%;" type="text"/></p>	<p>Did your body strike the inside of your vehicle?..... Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If Yes, describe: <input style="width:100%;" type="text"/></p> <p>Did you lose consciousness during the injury?..... Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If Yes, for how long? <input style="width:100%;" type="text"/></p> <p>Your vehicle's Estimated Damage: <input style="width:100%;" type="text"/></p> <p>Damage to their vehicle: <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Totaled</p>
<p>Address:</p> <p>City, State, Zip: <input style="width:100%;" type="text"/></p> <p>Home Phone: <input style="width:100%;" type="text"/> Work Phone: <input style="width:100%;" type="text"/></p> <p>Social Security No: <input style="width:100%;" type="text"/></p> <p>Date of Birth: <input style="width:100%;" type="text"/></p> <p>Date of Injury/Onset: <input style="width:100%;" type="text"/></p>	<p>Time/Speed/Damage</p> <p>Time of Accident: <input style="width:100%;" type="text"/> Your Speed <input style="width:100%;" type="text"/> Their Speed <input style="width:100%;" type="text"/></p> <p>Damage to your vehicle: <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Totaled</p>	<p>Did police show up at the scene? Yes <input type="checkbox"/> No <input type="checkbox"/> Was an accident report filled out? Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Dominant Hand: <input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both</p> <p>Insurance Information:</p> <p>Policy Holder (if different than patient): <input style="width:100%;" type="text"/></p> <p>Policy No: <input style="width:100%;" type="text"/> Claim No: <input style="width:100%;" type="text"/></p>	<p>What was your vehicle doing at time of accident?</p> <p><input type="radio"/> Stopped at intersection <input type="radio"/> Stopped in traffic <input type="radio"/> Stopped at a light <input type="radio"/> Making a right turn <input type="radio"/> Making a left turn <input type="radio"/> Parking <input type="radio"/> Proceeding along <input type="radio"/> Slowing down <input type="radio"/> Accelerating</p> <p>Other: <input style="width:100%;" type="text"/></p>	<p>Emergency Room?</p> <p>Where did you go after the accident? <input style="width:100%;" type="text"/> How did you get there? <input type="radio"/> Home <input type="radio"/> Work <input type="radio"/> Drove Self <input type="radio"/> Ambulance <input type="radio"/> Hospital ER <input type="radio"/> Private doctor <input type="radio"/> Somebody Else <input type="radio"/> Police</p>
<p>Description of Accident/Injury/Onset</p> <p>If this is an automobile accident, you can use the MVA Section.</p> <p style="height: 100px;"></p>	<p>Details of Accident:</p> <p>Visibility at the time: <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor</p> <p>Road Conditions at Time of Accident: <input type="radio"/> Icy <input type="radio"/> Wet <input type="radio"/> Sandy <input type="radio"/> Dark <input type="radio"/> Clean & Dry</p> <p>Point of Impact: <input type="radio"/> Head-On <input type="radio"/> Rear-End <input type="radio"/> Left front <input type="radio"/> Right front <input type="radio"/> Left rear <input type="radio"/> Right rear</p> <p>Other: <input style="width:100%;" type="text"/></p>	<p>X-rays done? Yes <input type="checkbox"/> No <input type="checkbox"/> Was lab work done? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Body parts X-rayed? <input style="width:100%;" type="text"/> What lab work? <input style="width:100%;" type="text"/></p> <p>The x-rays revealed: <input style="width:100%;" type="text"/></p> <p>Treatments: <input type="checkbox"/> Cervical Collar <input type="checkbox"/> Ice Other <input style="width:100%;" type="text"/></p> <p>Medications: <input style="width:100%;" type="text"/></p> <p>Follow-up Instructions: <input style="width:100%;" type="text"/></p>
<p>During and after accident details</p> <p>Enter details of your condition during and after the injury/onset.</p> <p style="height: 100px;"></p>	<p>Additional Accident Information:</p> <p>In the case of a motor vehicle accident, write any additional info here.</p> <p style="height: 100px;"></p>	<p>After the Accident:</p> <p>Check off the symptoms right after and a few days following the accident.</p> <p><input type="checkbox"/> Headache <input type="checkbox"/> Loss of smell <input type="checkbox"/> Tension <input type="checkbox"/> Loss of taste <input type="checkbox"/> Diarrhea <input type="checkbox"/> Neck pain <input type="checkbox"/> Dizziness <input type="checkbox"/> Irritability <input type="checkbox"/> Toe numbness <input type="checkbox"/> Depression <input type="checkbox"/> Neck stiffness <input type="checkbox"/> Nausea <input type="checkbox"/> Mid back pain <input type="checkbox"/> Constipation <input type="checkbox"/> Anxious <input type="checkbox"/> Fainting <input type="checkbox"/> Confusion <input type="checkbox"/> Low back pain <input type="checkbox"/> Cold hands <input type="checkbox"/> Chest pain <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Fatigue <input type="checkbox"/> Nervousness <input type="checkbox"/> Cold Feet <input type="checkbox"/> Pain behind eyes <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Sleeping problems</p> <p>Others: <input style="width:100%;" type="text"/></p>
<p>During the Accident:</p> <p>Body Position, etc.</p> <p>Did you see the accident coming?..... Yes <input type="checkbox"/> No <input type="checkbox"/> Were you braced for the impact?..... Yes <input type="checkbox"/> No <input type="checkbox"/> Did you have a seat belt on?..... Yes <input type="checkbox"/> No <input type="checkbox"/> Did you have a shoulder harness on? Yes <input type="checkbox"/> No <input type="checkbox"/> Did the driver's front air bag deploy?.. Yes <input type="checkbox"/> No <input type="checkbox"/> Did passenger front air bags deploy? Yes <input type="checkbox"/> No <input type="checkbox"/> Did the side air bags deploy?..... Yes <input type="checkbox"/> No <input type="checkbox"/> Does your vehicle have headrests?... Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Headrest Position?</p> <p><input type="radio"/> Even with top of head <input type="radio"/> Even with bottom of head <input type="radio"/> Even with middle of the neck</p>	<p>What was the direction of the head at the time of impact?</p> <p><input type="radio"/> Facing straight forward <input type="radio"/> Turned to the right <input type="radio"/> Turned to the left</p>	<p>Doctor's Additional Data on This Patient</p> <p>NOTE: This will be entered into the chart, but will not appear in Reports</p> <p style="height: 100px;"></p>

Patient's Signature: _____

Date: _____

Historical Information

Prior Treatment Information

Prior Similar Symptoms: <input type="radio"/> I have NOT had prior similar symptoms to current complaints. <input type="radio"/> My current complaints DID exist before, but had been dormant. <input type="radio"/> My current complaints ALREADY existed and were worsened.		Has your History Contributed to your Symptoms? <input type="radio"/> My history HAS contributed to my current symptoms. <input type="radio"/> My history HAS NOT contributed to my current symptoms. <input type="radio"/> I'm NOT SURE if my history has contributed to my symptoms.		My Most Recent Prior Similar Symptoms (if applicable) My most recent prior similar symptoms occurred... <input type="checkbox"/> Months <input type="checkbox"/> Years...ago OR on (Date) <input type="text"/>																					
Medical History Section: Enter additional Medical Historical data here.		Surgical Historical Section: Enter any Surgical Historical data here.		Treatment History 1: Fill in any other doctor(s) seen prior to your first visit to this office. <table border="0" style="width: 100%;"> <tr> <td style="width: 60%;">2. Name: <input type="text"/></td> <td style="width: 20%;">Specialty: <input type="text"/></td> <td style="width: 10%; text-align: right;">First Visit Date</td> <td style="width: 10%;"><input type="text"/></td> </tr> <tr> <td colspan="3"></td> <td style="text-align: right;">Last Visit Date</td> </tr> <tr> <td colspan="3">Types of Treatments Received: <input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>How many Tx's Received?</td> <td>Did Tx's help?</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>X-rays done?</td> </tr> <tr> <td><input type="text"/></td> <td>Currently Treating?</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> </table>		2. Name: <input type="text"/>	Specialty: <input type="text"/>	First Visit Date	<input type="text"/>				Last Visit Date	Types of Treatments Received: <input type="text"/>			<input type="text"/>	How many Tx's Received?	Did Tx's help?	Yes <input type="checkbox"/> No <input type="checkbox"/>	X-rays done?	<input type="text"/>	Currently Treating?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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Medications History Section: Enter any Medications Historical data here.		Occupational History Section: Enter Occupational History, e.g. lost work, etc. Here.		Treatment History 2: Fill in any other doctor(s) seen prior to your first visit to this office. <table border="0" style="width: 100%;"> <tr> <td style="width: 60%;">2. Name: <input type="text"/></td> <td style="width: 20%;">Specialty: <input type="text"/></td> <td style="width: 10%; text-align: right;">First Visit Date</td> <td style="width: 10%;"><input type="text"/></td> </tr> <tr> <td colspan="3"></td> <td style="text-align: right;">Last Visit Date</td> </tr> <tr> <td colspan="3">Types of Treatments Received: <input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>How many Tx's Received?</td> <td>Did Tx's help?</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>X-rays done?</td> </tr> <tr> <td><input type="text"/></td> <td>Currently Treating?</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> </table>		2. Name: <input type="text"/>	Specialty: <input type="text"/>	First Visit Date	<input type="text"/>				Last Visit Date	Types of Treatments Received: <input type="text"/>			<input type="text"/>	How many Tx's Received?	Did Tx's help?	Yes <input type="checkbox"/> No <input type="checkbox"/>	X-rays done?	<input type="text"/>	Currently Treating?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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Patient's Signature: _____ Date: _____

Current Complaints

1. Location of Pain:	Does this Pain Radiate?	2. Location of Pain:	Does this Pain Radiate?
<input type="checkbox"/> Headaches LO RO BO ○ Front of Head ○ Top and/or Sides ○ Back of Head <input type="checkbox"/> Jaw..... LO RO BO <input type="checkbox"/> Eye..... LO RO BO <input type="checkbox"/> Neck..... LO RO BO <input type="checkbox"/> Uppr. Back... LO RO BO <input type="checkbox"/> Mid Back.... LO RO BO <input type="checkbox"/> Low Back.... LO RO BO <input type="checkbox"/> Chest..... LO RO BO <input type="checkbox"/> Abdomen.... LO RO BO <input type="checkbox"/> Ribs..... LO RO BO <input type="checkbox"/> Buttocks.... LO RO BO <input type="checkbox"/> Shoulder.... LO RO BO <input type="checkbox"/> Uppr. Arm... LO RO BO <input type="checkbox"/> Foreman.... LO RO BO <input type="checkbox"/> Hand..... LO RO BO <input type="checkbox"/> Hip..... LO RO BO <input type="checkbox"/> Leg..... LO RO BO <input type="checkbox"/> Foot..... LO RO BO Other Locations: <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	<input type="checkbox"/> Head..... LO RO BO <input type="checkbox"/> Neck..... LO RO BO <input type="checkbox"/> Shoulder... LO RO BO <input type="checkbox"/> Arm..... LO RO BO <input type="checkbox"/> Hand..... LO RO BO <input type="checkbox"/> Hip..... LO RO BO <input type="checkbox"/> Leg..... LO RO BO <input type="checkbox"/> Foot..... LO RO BO Other Locations: <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	<input type="checkbox"/> Headaches LO RO BO ○ Front of Head ○ Top and/or Sides ○ Back of Head <input type="checkbox"/> Jaw..... LO RO BO <input type="checkbox"/> Eye..... LO RO BO <input type="checkbox"/> Neck..... LO RO BO <input type="checkbox"/> Uppr. Back.. LO RO BO <input type="checkbox"/> Mid Back.... LO RO BO <input type="checkbox"/> Low Back.... LO RO BO <input type="checkbox"/> Chest..... LO RO BO <input type="checkbox"/> Abdomen.... LO RO BO <input type="checkbox"/> Ribs..... LO RO BO <input type="checkbox"/> Buttocks.... LO RO BO <input type="checkbox"/> Shoulder.... LO RO BO <input type="checkbox"/> Uppr. Arm... LO RO BO <input type="checkbox"/> Foreman.... LO RO BO <input type="checkbox"/> Hand..... LO RO BO <input type="checkbox"/> Hip..... LO RO BO <input type="checkbox"/> Leg..... LO RO BO <input type="checkbox"/> Foot..... LO RO BO Other Locations: <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	<input type="checkbox"/> Head..... LO RO BO <input type="checkbox"/> Neck..... LO RO BO <input type="checkbox"/> Shoulder... LO RO BO <input type="checkbox"/> Arm..... LO RO BO <input type="checkbox"/> Hand..... LO RO BO <input type="checkbox"/> Hip..... LO RO BO <input type="checkbox"/> Leg..... LO RO BO <input type="checkbox"/> Foot..... LO RO BO Other Locations: <div style="border: 1px solid black; height: 15px; width: 100%;"></div>
Types of Pain: <input type="checkbox"/> Dull <input type="checkbox"/> Numbing <input type="checkbox"/> Throbbing <input type="checkbox"/> Shooting <input type="checkbox"/> Spasm <input type="checkbox"/> Cutting <input type="checkbox"/> Sharp <input type="checkbox"/> Tingling <input type="checkbox"/> Burning <input type="checkbox"/> Pounding <input type="checkbox"/> Stinging <input type="checkbox"/> Cramping <input type="checkbox"/> Aching <input type="checkbox"/> Constricting Other Types of Pain: <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	Actions Affecting Pain B=Brings on A=Aggravates R=Relieves B A R <input type="checkbox"/> In the A.M. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> In the P.M. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bending Fwd <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bending Back <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bending Left <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bending Rt. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Twisting Left <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Twisting Rt. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Coughing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sneezing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Straining <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Standing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sitting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lifting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other Actions: <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	Types of Pain: <input type="checkbox"/> Dull <input type="checkbox"/> Numbing <input type="checkbox"/> Throbbing <input type="checkbox"/> Shooting <input type="checkbox"/> Spasm <input type="checkbox"/> Cutting <input type="checkbox"/> Sharp <input type="checkbox"/> Tingling <input type="checkbox"/> Burning <input type="checkbox"/> Pounding <input type="checkbox"/> Stinging <input type="checkbox"/> Cramping <input type="checkbox"/> Aching <input type="checkbox"/> Constricting Other Types of Pain: <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	Actions Affecting Pain B=Brings on A=Aggravates R=Relieves B A R <input type="checkbox"/> In the A.M. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> In the P.M. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bending Fwd <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bending Back <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bending Left <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bending Rt. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Twisting Left <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Twisting Rt. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Coughing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sneezing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Straining <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Standing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sitting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lifting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other Actions: <div style="border: 1px solid black; height: 15px; width: 100%;"></div>
Pain Frequency: <input type="checkbox"/> Up to 1/4 of awake time <input type="checkbox"/> 1/4 to 1/2 of awake time <input type="checkbox"/> 1/2 to 3/4 of awake time <input type="checkbox"/> Most all the time	Pain Intensity: <input type="checkbox"/> Doesn't affect daily activities <input type="checkbox"/> Somewhat affects activities <input type="checkbox"/> Seriously affects activities <input type="checkbox"/> Prevents activities	Pain Frequency: <input type="checkbox"/> Up to 1/4 of awake time <input type="checkbox"/> 1/4 to 1/2 of awake time <input type="checkbox"/> 1/2 to 3/4 of awake time <input type="checkbox"/> Most all the time	Pain Intensity: <input type="checkbox"/> Doesn't affect daily activities <input type="checkbox"/> Somewhat affects activities <input type="checkbox"/> Seriously affects activities <input type="checkbox"/> Prevents activities
Additional Data on above Symptom <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		Additional Data on above Symptom <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Patient's Signature: _____ **Date:** _____

Activities of Daily Living

Activities of Daily Living Scale #1 Use the following 1 to 5 Scale to describe the difficulties below, down through Travelling.	1 - "I can do it without any difficulty." 2 - "I can do it without much difficulty, despite some pain." 3 - "I manage to do it by myself, despite marked pain."	4 - "I manage to do it, despite the pain, but only if I have help." 5 - "I cannot do it at all, because of the pain."
Difficulties with Self Care and Personal Hygiene Activities: Bathing... <input type="checkbox"/> Drying hair... <input type="checkbox"/> Brushing teeth... <input type="checkbox"/> Putting on shoes... <input type="checkbox"/> Preparing meals... <input type="checkbox"/> Taking out trash... <input type="checkbox"/> Showering... <input type="checkbox"/> Combing hair... <input type="checkbox"/> Making bed... <input type="checkbox"/> Tying shoes... <input type="checkbox"/> Eating... <input type="checkbox"/> Doing laundry... <input type="checkbox"/> Washing hair... <input type="checkbox"/> Washing face... <input type="checkbox"/> Putting on shirt... <input type="checkbox"/> Putting on pants... <input type="checkbox"/> Cleaning dishes... <input type="checkbox"/> Going to toilet... <input type="checkbox"/>		
Difficulties with Physical Activities: Standing..... <input type="checkbox"/> Walking... <input type="checkbox"/> Kneeling... <input type="checkbox"/> Bending back... <input type="checkbox"/> Twisting left... <input type="checkbox"/> Leaning back... <input type="checkbox"/> Sitting... <input type="checkbox"/> Stooping... <input type="checkbox"/> Reaching... <input type="checkbox"/> Bending left... <input type="checkbox"/> Twisting right... <input type="checkbox"/> Leaning left... <input type="checkbox"/> Reclining... <input type="checkbox"/> Squatting... <input type="checkbox"/> Bending forward... <input type="checkbox"/> Bending right... <input type="checkbox"/> Leaning forward... <input type="checkbox"/> Leaning right... <input type="checkbox"/> Standing for long periods... <input type="checkbox"/> Sitting for long periods... <input type="checkbox"/> Walking for long periods... <input type="checkbox"/> Kneeling for long periods... <input type="checkbox"/>		
Difficulties with Functional Activities: Carrying small objects... <input type="checkbox"/> Lifting weights off floor... <input type="checkbox"/> Pushing things while seated... <input type="checkbox"/> Exercising upper body... <input type="checkbox"/> Carrying large objects... <input type="checkbox"/> Lifting weights off table... <input type="checkbox"/> Pushing things while standing... <input type="checkbox"/> Exercising lower body... <input type="checkbox"/> Carrying brief case... <input type="checkbox"/> Climbing stairs... <input type="checkbox"/> Pulling things while seated... <input type="checkbox"/> Exercising arms... <input type="checkbox"/> Carrying large purse... <input type="checkbox"/> Climbing inclines... <input type="checkbox"/> Pulling things while standing... <input type="checkbox"/> Exercising legs... <input type="checkbox"/>		
Difficulties with Social and Recreational Activities: Bowling... <input type="checkbox"/> Jogging... <input type="checkbox"/> Swimming... <input type="checkbox"/> Ice skating... <input type="checkbox"/> Competitive sports... <input type="checkbox"/> Dating... <input type="checkbox"/> Golfing... <input type="checkbox"/> Dancing... <input type="checkbox"/> Skiing... <input type="checkbox"/> Roller skating... <input type="checkbox"/> Hobbies... <input type="checkbox"/> Dining out... <input type="checkbox"/>		
Difficulties with Travelling: Driving a motor vehicle... <input type="checkbox"/> As a passenger in a motor vehicle... <input type="checkbox"/> As a passenger on a train... <input type="checkbox"/> Driving for long periods of time... <input type="checkbox"/> As airplane passenger... <input type="checkbox"/>		
Activities of Daily Living Scale #2 Use the following 1 to 5 Scale to describe the difficulties below	1 - "This area is not affected by my condition." 2 - "This area is slightly affected by my condition." 3 - "My condition moderately restricts my ability in this area."	4 - "My condition seriously limits my ability in this area." 5 - "My condition prevents me from using this ability."
Difficulties with Different Forms of Communication: Concentrating... <input type="checkbox"/> Hearing... <input type="checkbox"/> Listening... <input type="checkbox"/> Speaking... <input type="checkbox"/> Reading... <input type="checkbox"/> Writing... <input type="checkbox"/> Using a keyboard... <input type="checkbox"/>		
Difficulties with the Senses: Seeing... <input type="checkbox"/> Hearing... <input type="checkbox"/> Touch... <input type="checkbox"/> Taste... <input type="checkbox"/> Sense of Smell... <input type="checkbox"/>		Difficulties with Hand Functions: Grasping... <input type="checkbox"/> Holding... <input type="checkbox"/> Pinching... <input type="checkbox"/> Percussive movements... <input type="checkbox"/> Sensory discrimination... <input type="checkbox"/>
Difficulties with Sleep and Sexual Activity: Being able to have a normal, restful nights sleep... <input type="checkbox"/> Being able to participate in desired sexual activity... <input type="checkbox"/>		Additional Activities of Daily Living Information:

Patient's Signature: _____ **Date:** _____



Health Conditions

Please check any conditions that currently exist or have existed in the past:

For women:	
Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you nursing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you experience painful periods?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have irregular cycles?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you taking birth control?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have breast implants?	<input type="checkbox"/> Yes <input type="checkbox"/> No

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he 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 expenses 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.

_____	_____	_____	_____
Patient's Signature	Date	Guardian or Spouse's Signature Authorizing Care	Date

Who should receive bills for payment on your account:

- | | | |
|--|--|-----------------------------------|
| <input type="checkbox"/> Patient | <input type="checkbox"/> Spouse | <input type="checkbox"/> Parent |
| <input type="checkbox"/> Worker's Comp | <input type="checkbox"/> Auto Insurance | <input type="checkbox"/> Medicare |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Personal Health Insurance | |

Ownership of X-ray Films

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

CONSENT TO TREATMENT OF MINOR

I/we, the undersigned, parent(s)/person having legal custody/legal guardianship of _____, a minor, do hereby authorize _____ as agent(s) for the undersigned to consent to any x-ray examination and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, to be rendered under the general or special supervision of any licensed chiropractor. It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above-described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable. These authorizations shall remain effective until _____, 20____, unless sooner revoked in writing delivered to the agent(s) noted above.

_____	_____
Parent/legal guardian / Person having legal custody (circle relationship)	Date



TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and when a chiropractor accepts a patient for such care, it is essential that both are speaking and working for the same goals. Chiropractic does NOT diagnose or treat disease. Chiropractic has only one goal:

To locate, analyze, and correct spinal interference to the nervous system.

The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The SUBLUXATION (spinal misalignment producing nerve interference), in and of itself, is a detriment to life and health. Correction of the subluxation through a specific chiropractic adjustment allows the body to function at its optimum level. This allows the INNATE healing power of the body to work at maximum efficiency to restore, maintain, and promote natural health.

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WE DO NOT DIAGNOSE CONDITION(S) OR DISEASE(S)  
OTHER THAN VERTEBRAL SUBLUXATIONS

WE OFFER NO OTHER TREATMENT OF CONDITION(S) OR DISEASE(S)  
OTHER THAN VERTEBRAL SUBLUXATIONS.

WE PROMISE NO CURE FROM ANY CONDITION(S) OR DISEASE(S).

**THE CHIROPRACTIC ADJUSTMENT RESTORES LIFE AND HEALTH TO ITS FULLEST POTENTIAL!!!**

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I, _____, having read the above statement, and understanding it fully, do undertake chiropractic health care on this basis.

SIGNATURE: _____ DATE: _____

Canyon Chiropractic _____ **Dedicated to Quality Care**



NEW PATIENT INSURANCE REGISTRATION FORM

Understanding your insurance coverage can be challenging. Our goal is to assist you in maximizing your benefits. We work with hundreds of different insurance companies that administer insurance benefits from different employers. Each employer pays an insurance premium for specific chiropractic coverage. Each plan is slightly different depending on how the employer has negotiated benefits with the insurance company. Companies often change insurance companies in an effort to secure better benefits for smaller premiums. We encourage you to become familiar with your policy maximums, percentages, exclusions, deductible and required co-payments.

We do not base your adjustment program on your insurance coverage and neither should you. There are limits to what they will pay. Our goal is to correct your problem in the shortest amount of time and in the most cost-effective manner.

Our courtesy service to you includes:

1. Researching your chiropractic insurance plan to advise you of benefits available to you.
2. Filing your insurance within 14 days of your visit and requesting payment of benefits to our office when possible.
3. Follow up on chiropractic claims to assist with claim processing and payment.

Our expectations of you as the owner of the insurance policy:

1. Payment of fees not covered by your insurance plan.
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance company.
3. Taking responsibility for payment if the insurance company does not pay our office.
4. Keeping our office informed of any changes in your insurance coverage or employment.

To assist us in obtaining your benefits, **please sign the "assignment of benefits"** below to allow us to file your insurance claims.

I hereby authorize Dr. Robert C. Dees to release to my insurance company, information acquired in the course of my chiropractic care. I hereby authorize benefits to be paid to Dr. Robert C. Dees. I understand I am responsible for any unpaid balance.

Signature: _____

Date: _____

Provider Privacy Policy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES

Treatment: Your health information may be disclosed to other health care professionals for the purpose of evaluating your health and providing treatment. For example, customer service information may be available to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the daily operations and management of Supplier. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to law enforcement agencies to assist in government audits and inspections, to facilitate law enforcement investigations, and to comply with government-mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Marketing: We may use your oral or written testimony, with your permission, for marketing the benefits of our office.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Information about treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual rights: You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Supplier's duties: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to revise privacy practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice. The revised policies and practices will be applied to all protected health information we maintain.

Requests to inspect protected health information: You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting **Canyon Chiropractic**. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints: If you would like to submit a comment or complaint about your privacy practices, you can do so by sending a letter outlining your concerns to:

Canyon Chiropractic
2570 San Ramon Valley Blvd. Suite A106
San Ramon, CA 94583

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact person: The name and address of the person you may contact for further information concerning our privacy practices is:

Robert C. Dees, DC
2570 San Ramon Valley Blvd. Suite A106
San Ramon, CA 94583
(925) 867-1414

The undersigned hereby acknowledges that he/she has read and understood the policies of the supplier.

Signature

Date

Print Name

Effective Date: This notice is effective after January 5, 2011