Personal Injury / Accident Medical History Intake Form

(Mark a ✓ on each that applies)

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M F

Marital Status: □ Single □ Married □ Separated □ Divorced □ Co-Habitant Sig.Other’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_/\_\_\_\_/\_\_\_\_ Height \_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Social Security No.: \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ Driver’s License No.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cellular Phone.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Insurance / Attorney Information:

Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last) (First) (Init)

Relation to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.: \_\_\_\_\_\_\_\_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you at fault?  Yes  No Insurance Company of the Person at Fault: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Have you retained an attorney?  Yes  No

Your Attorney’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Attorney’s Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Attorney’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

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Accident Information: (Mark a ✓ on each that applies to the accident)

Date of Accident: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Time of Accident: \_\_\_\_\_\_\_\_\_\_\_\_ a.m. / p.m.

What type of accident is this injury related to?  Auto  Work  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe Accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If Motor Vehicle Accident:** Your Vehicle: Year \_\_\_\_\_\_\_\_\_\_\_\_\_ Make \_\_\_\_\_\_\_\_\_\_\_Model\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Vehicle: Year \_\_\_\_\_\_\_\_\_\_\_\_\_ Make \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Model\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Accident Type: Rear ended Head-on Broad-sided Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you the:  Driver  Passenger: If passenger, where were you sitting:  Front Seat  Back Seat

Did the airbag deploy:  Yes No Were you wearing a Seat Belt:  Yes  No

Impending Collision, were you:  Aware  Unaware  Braced  Not braced

Did your head:  Strike Object  Not strike Object  Break Glass  Other

Did you experience: Shock Loss of Consciousness Whiplash Nausea  Other

The Weather Conditions were they:  Sunny  Raining  Snowing  Foggy

The Road was:  Dry  Wet  Icy

State your emotions and physical state immediately following the accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

State your emotions & physical state after the first few days: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Immediately following the accident: (Mark a ✓ on each that applies to the accident)

Ambulance / Paramedics were called I was treated at the scene

I was transported to Hospital by Ambulance I went to Hospital in my own

­­I was diagnosed at the Hospital I was treated at the Hospital

Medication was prescribed Follow-up was recommended

Other Doctors Seen:

Orthopedist Neurologist Psychiatrist Physiatrist

Acupuncturist General Practitioner Physical Therapist Massage Therapist

Chiropractor Other:\_\_\_\_\_\_\_\_\_\_\_\_

Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List the treatments you have had for your problem:

Chiropractic  Osteopathy  Trigger Point Injections  Epidural Injections

Acupuncture  Naturopathy  Hot packs  Ultrasound  Diathermy  Massage

Electrical Stimulation Biofeedback  TENS Unit  Body Mechanics Training

Strengthening Exercises  Aerobics  Gravity Inversion / Traction  Bed Rest

Back Brace  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List the types of Diagnostic Testing that has been performed for this problem:

X-Rays  C.T. Scan  Myelogram  M.R.I. Scan  Discogram  Bone Scan

E.M.G.  N.C.S.

List Past Surgeries:  None

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

List Past Hospitalizations:  None

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List previous back, neck and musculoskeletal problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Symptomatology: (Pain characteristics for major area of complaint)

The pain is located: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The pain started: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The pain has the following qualities:

* Sharp
* Shooting
* Dull
* Achy
* Numb
* Tingly
* Stiff
* Burning
* Throbbing
* Other\_\_\_\_\_

The pain is made better by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

and worse by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

There is radiation into: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Daily Activities:

How many days out of an average week do you have pain?  >1  2-5  5-7

How much time out of an average day are you in pain?  Always  Sometimes  Never

What are the worst times of day for the pain?  Morning  Noon Evening  Other

When do you feel the best?  Morning  Noon Evening  Other

Pain Rating: *On a scale of 0 – 10, rate your pain: (Please ⭘ the number that best describes your pain)*

No Pain Severe Pain

0 1 2 3 4 5 6 7 8 9 10

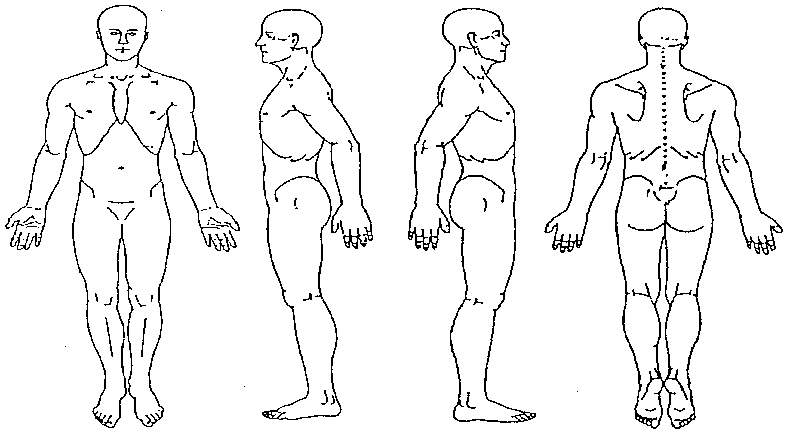
Describe the overall severity of the pain:

Mild Nuisance

Mild to moderate, but can live with it

Moderate, having trouble coping with it

Severe, it is ruining my quality of life



Please use the legend symbols below to accurately mark the areas in which you feel thesesensations:

Stabbing/Cutting-//// Tingling-\*\*\*\* Burning-XXXX Cramping- ^^^^

Numbness-NNNN Dull-####

How do the following activities affect your pain?

No Change Relieves Increased Duration

Sitting    \_\_\_\_\_\_\_\_

Walking    \_\_\_\_\_\_\_\_

Standing    \_\_\_\_\_\_\_\_

Lying Down    \_\_\_\_\_\_\_\_

Looking up    \_\_\_\_\_\_\_\_

Looking Down    \_\_\_\_\_\_\_\_

Lifting    \_\_\_\_\_\_\_\_

Progression:

How is your pain compared to when the pain episode first started?

Much Improved  Somewhat Improved  Much Worse  Somewhat Worse No Change

Please mark a ✓ on each that applies to your daily activities:

Have difficulty climbing stairs.

Have to use handrails to get up stairs, etc.

Have to hold onto something to sit or stand from a chair.

Stay at home most of the time.

Do not do jobs around the house.

Walk slower than usual.

Can only walk short distances.

Have to sit most of the day.

Can only stand for short periods of time.

Stays in bed most of the day.

Change position frequently to try and get comfortable.

Have difficulty turning over in bed.

Have to lie down and rest frequently.

Have difficulty sleeping.

Have to get other people to do things for me.

Have difficulty getting dressed.

Have to get dressed with someone’s help.

Have difficulty bending or kneeling.

Have a loss of appetite.

Have more irritable stages.

What are some recreational activities that you participated in before this current problem and which ones cannot be performed now to the same extent as before? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Social History:

Smoker  Yes  No How much? \_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_

Drink alcohol  Yes  No How much? \_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_

Take Drugs  Yes  No How much? \_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_

Medical History:

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

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

List any **vitamins/supplements/herbs** you are currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please mark a ✓ if you have had any of the following symptoms in the past 5 years.

Unexplained fevers  Night sweats  Weight loss of 10 lbs or more  Loss of appetite

Excessive fatigue  Depression  Difficulty sleeping  Easy bruising

Excessive bleeding  Swollen ankles  Lumps in neck, armpit or groin  Chest pain or tightness  Trouble breathing with exercise  Trouble breathing lying flat  Coughing up blood

Stomach pain  Diarrhea  Change in bowel habits  Excessive constipation  Dark black stools  Blood in stools  Pain when urinating Difficulty urinating

Eye redness  Coughing  Joint pain  Urinating at night  Skin rashes  Blood in urine  Morning stiffness  Swelling

How would you rate your energy level?  Excellent  Very Good  Good  Fair  Poor

What type of exercise do you do?  Strenuous  Moderate  Light  None

How frequently do you exercise? \_\_\_\_\_\_ x week / month *(Please circle one)*

Place a mark on “Yes” or “No” to indicate if you have had any of the following:

AIDS/HIV  Yes  No Diabetes  Yes  No Kidney Problem  Yes  No Rheumatoid Arthritis  Yes  No

Alcoholism  Yes  No Emphysema  Yes  No Liver Disease  Yes  No Rheumatic Fever  Yes  No

Allergy Shots  Yes  No Epilepsy  Yes  No Measles/Mumps  Yes  No Scarlet Fever  Yes  No

Anemia  Yes  No Fractures  Yes  No Migraines  Yes  No STD  Yes  No

Anorexia  Yes  No Glaucoma  Yes  No Miscarriage  Yes  No Stroke  Yes  No

Appendicitis  Yes  No Goiter  Yes  No Mononucleosis  Yes  No Suicide Attempt  Yes  No

Arthritis  Yes  No Gonorrhea  Yes  No Multiple Sclerosis  Yes  No Thyroid Problem  Yes  No

Asthma  Yes  No Gout  Yes  No Osteoporosis  Yes  No Tonsillitis  Yes  No

Bleeding Disorder Yes  No Heart Disease  Yes  No Pacemaker  Yes  No Tuberculosis  Yes  No

Breast Lump  Yes  No Hepatitis  Yes  No Parkinson’s  Yes  No Tumors  Yes  No

Bronchitis  Yes  No Hernia  Yes  No Pinched Nerve  Yes  No Typhoid Fever  Yes  No

Bulimia  Yes  No Herniated Disc  Yes  No Pneumonia  Yes  No Ulcers  Yes  No

Cancer  Yes  No Herpes  Yes  No Polio  Yes  No Vaginal Infections  Yes  No

Cataracts  Yes  No High Blood Pressure Yes  No Prosthesis  Yes  No Whooping Cough  Yes  No

Chicken Pox  Yes  No High Cholesterol  Yes  No Psychiatric Care  Yes  No Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen a Chiropractor Before?  No  Yes If yes, how was your visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anything else pertinent to your visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Signature Date

To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Re: Medical Reports and Doctor’s Lien

I authorized the above doctor and/or their authorized representatives to furnish my attorney, any attorney or attorneys who subsequently are either associated with the said attorney or substituted in their place, with a full report of my examination, diagnosis, treatment, prognosis, itemized bill of charges incurred, etc. in regard to the accident in which I was involved on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and hold the above doctor free and harmless from any liability in such transfer of information.

Out of the proceeds of the settlement and/or judgment in my claim for personal injuries, I hereby assign, set over and transfer to the above doctor such monies due and owing to him or the group for medical, chiropractic, x-rays, physical therapy, supplies and/or laboratory fees rendered to me, either by reason of the above accident or otherwise. I further give to the above doctor a lien on any and all funds received by me or in my behave in association with the settlement or satisfaction of judgment arising from claims presented on my behalf.

I fully understand that I am directly responsible to said doctors/group for all medical bills submitted by them for services rendered to me. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually receive said fee. In the event legal action shall be brought in order to enforce this lien, then the prevailing party shall be entitled to reasonable costs and attorney fees in addition to any judgment rendered. It is acknowledged by the undersigned that this assignment and lien is further consideration for the services rendered by the above doctor in addition to the obligation to pay for the medical services.

Patient’s personal injury claim medical payments are hereby assigned and will be paid directly from the insurance company to **Novi Holistic Health.**

Attorney agrees to notify the doctors immediately of the name and contacting information of any attorney substituted in his or her place.

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

Print Patient Name Date

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

Signature of Patient Signature of Parent/Guardian

Acknowledgement of assignment and lien by attorney

The undersigned being the attorney of record on his own behalf and on behalf of any other attorney or attorneys who are associated with the undersigned or who are substituted in his stead for the above patient, does hereby acknowledge receipt of a copy of the assignment and lien, and said attorney acknowledges that he/she obligates themselves to the terms of the assignment and lien in consideration for the rendering of medical services to their client by the above doctor and rendering of a report and bill to said attorney. In the event legal action shall be brought in order to enforce this lien, then the prevailing party shall be entitled to reasonable costs and attorney fees in addition to any judgment rendered. A photographic reproduction of this authorization may be used in place of the original. No charges or alterations of the monies billed herein will be accepted unless confirmed in writing by the doctor. Please date, sign and return on copy as soon as possible to the above referenced medical provider of service in order that treatment can continue on the herein contained lien basis.

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

Attorney’s Signature Date

**ARBITRATION AGREEMENT**

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Pennsylvania and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**Article 2: All Claims Must be Arbitrated:** It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider’s clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider’s associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

**Article 3: Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party’s pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party’s own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration.

**Article 4: General Provision:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

**Article 5: Revocation:** This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

**Article 6: Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. \_\_\_\_\_\_\_. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

Signed this day of, month of , 20\_\_

In the presence of:

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

Witness First Party Witness Second Party

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

Patient’s Name (Please Print) Patient’s Signature

**CHIROPRACTIC INFORMED CONSENT TO TREAT**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. 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 upon the facts then known, is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Or Patient Guardian/Parent/Representative)

Provide name and relationship if signing for patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_