

# Personal Injury Intake Form

It is necessary that if your injuries are due to an automobile accident that we are given the following information within your first 2 visits or you may become responsible for continued charges. It is necessary to complete the following forms to best of your ability. Detail is imperative.

Patient Name: \_\_\_\_\_

Patient Auto Insurance Name: \_\_\_\_\_

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

Claim Number: \_\_\_\_\_ Adjuster Name: \_\_\_\_\_

Adjuster Phone Number: \_\_\_\_\_ Date of Accident: \_\_\_\_\_ Time: \_\_\_\_\_

Where did the accident happen? \_\_\_\_\_

Describe the accident in your own words:

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What was your position in the car?  Driver  Passenger

If passenger, were you sitting in  Front  Right Rear  Left Rear

Did your vehicle strike other vehicle?  Yes  No      Was your car struck by other vehicle?  Yes  No

Was the impact from:  the front  from the right side  from the left side  from the rear

At the time of impact were you:  looking straight ahead  looking right  looking left

Were both hands on the steering wheel?  Yes  No      Was your foot on the brake?  Yes  No

Were you braced for impact?  Yes  No

Where in the car were you after the accident? \_\_\_\_\_

Were you wearing seat belts?  Yes  No      Did you strike anything in the vehicle at the time of impact?  Yes  No

Please state part of body:  Chest  Chin  Knee  Shoulder  Hand  Head

Immediately following the accident how did you feel? \_\_\_\_\_

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Were you unconscious?  Yes  No      In a daze?  Yes  No

Did you go to the hospital?  Yes  No      How did you get to the hospital?  Ambulance  Private Transportation

Did the ambulance attendants place you in: Neck Collar  Yes  No      Splints  Yes  No      Brace  Yes  No

Name of Hospital: \_\_\_\_\_

Attended by Dr. \_\_\_\_\_

Were you x-rayed at the hospital?  Yes  No

If Yes, what was the diagnosis? \_\_\_\_\_

Were you admitted to the hospital?  Yes  No      How long did you stay? \_\_\_\_\_

What treatment was rendered? \_\_\_\_\_

What recommendations were made? See own doctor?  Yes  No      See orthopedic doctor?  Yes  No

Physical Therapy?  Yes  No

Have you seen any other doctor as a result of this accident?  Yes  No

Doctor's Name: \_\_\_\_\_

Is your pain constant?  Yes  No      Is the pain on and off?  Yes  No      Sharp?  Yes  No

Dull?  Yes  No

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

Is your pain worse when arising from a chair?  Yes  No

Is it made worse by straining?  Yes  No      By coughing?  Yes  No      By sneezing?  Yes  No

By straining when moving your bowels?  Yes  No

Do you have any numbness or tingling in your arms?  Yes  No      In your hands?  Yes  No

In your fingers?  Yes  No      In your legs?  Yes  No      In your feet?  Yes  No

In your toes?  Yes  No

What is your most comfortable position? Sitting  Yes  No      Lying on your right side  Yes  No

Lying on your left side  Yes  No      Lying on your back  Yes  No      On your stomach  Yes  No

Standing  Yes  No

Other \_\_\_\_\_

Is it difficult for you to move around in bed?  Yes  No      Does stretching and twisting worsen the pain?  Yes  No

Do any of the following relieve your pain?  Heating pad  Hot Bath  Shower  Ice pack

Does a brace (if you have tried one) help relieve the pain?  Yes  No

Does a change in heel height worsen the pain?  Yes  No

Do you feel better moving around?  Yes  No      Or resting?  Yes  No

Do you have a firm mattress?  Yes  No

Do your knees ache or hurt?  Yes  No

Do you have cramps in your leg?  Yes  No      In arm?  Yes  No

Have you had any change in your bowel habits?  Yes  No

Have you lots any time from work because of this accident?  Yes  No

If yes, give dates of time lost: From: \_\_\_\_\_ To: \_\_\_\_\_

Totally disabled from \_\_\_\_\_ to \_\_\_\_\_      Partially disabled from \_\_\_\_\_ to \_\_\_\_\_

Before Your Accident, estimate your total lifting effort ability:

1. How much weight?  Maximum  Average

2. How far could you carry this weight? \_\_\_\_\_ For how long a period of time? \_\_\_\_\_

3. Was this lifting done at work?  Yes  No      Or at home or elsewhere?  Yes  No

4. How often did you carry this amount of weight? \_\_\_\_\_

After Your Accident, describe your total lifting ability:

1. How much weight can you now lift without experiencing pain, discomfort, or restriction of motion?  
\_\_\_\_\_
2. Did you experience this pain, discomfort or restriction of motion before your accident?  Yes  No
3. How far can you carry this weight now? \_\_\_\_\_ And for how long a period of time? \_\_\_\_\_
4. How often can you carry this weight? \_\_\_\_\_
5. Are you now limited in your lifting ability in some body position that you were previously not?  Yes  No  
If so, specify position \_\_\_\_\_
6. What symptoms does lifting produce? \_\_\_\_\_
7. How long do these symptoms last? \_\_\_\_\_

Are you presently able to:

Lift:  Very Heavy \_\_\_\_\_ lbs     Heavy \_\_\_\_\_ lbs     Light \_\_\_\_\_ lbs     Sitting \_\_\_\_\_ lbs  
Work:  Very Heavy \_\_\_\_\_ lbs     Heavy \_\_\_\_\_ lbs     Light \_\_\_\_\_ lbs     Sitting \_\_\_\_\_ lbs

What positions can you work in with a minimum demand of physical effort?

With minimum demand of physical effort, what positions can you work in part-time and for how long?

Standing     Walking     Sitting

With minimum demand of physical effort, can work in a sitting position with some degree of walking or standing activity?  Yes  No

Do you feel that you cannot perform any physical work activity?  Yes  No

Do you feel that you cannot perform any mental work?  Yes  No

Relate your before injury capacity ( mark 'B' ) and your After injury capacity ( mark 'A' ) for performing activities:

- |              |              |               |                 |            |
|--------------|--------------|---------------|-----------------|------------|
| 1. Walking   | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 2. Standing  | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 3. Sitting   | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 4. Bending   | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 5. Stooping  | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 6. Lifting   | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 7. Pushing   | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 8. Pulling   | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 9. Climbing  | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 10. Reaching | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 11. Gripping | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 12. Kneeling | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 13. Balance  | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 14. Fatigue  | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |

Generally speaking, is your inability to perform these functions due to  Pain  Weakness  Structural limitations  
 Nerves ?

Are you able to take care of your personal self, such as dressing, bathing, etc?  Yes  No or do you require assistance?  Yes  No

Do you feel your present condition is temporary?  Yes  No or permanent?  Yes  No

Vehicles Involved:

Your Vehicle – Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_

Other Vehicle – Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_

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

Damage to Your Vehicle: \$ \_\_\_\_\_ Other Vehicle Damage: \$ \_\_\_\_\_

Air bag deployed?  Yes  No

The Road was:  Dry  Wet  Icy  Snowy

The Weather Conditions were:  Sunny  Cloudy  Foggy  Light Rain  Heavy Rain  Snowing

Time of Day:  Dawn  Day  Dusk  Night  Unknown

Other Doctors Seen:  Orthopedist  Psychiatrist  Massage Therapist  Neurologist

Physical Therapy  Chiropractor

Any other information you would like to share with us:

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## Louisville Family Chiropractic

8117 New LaGrange Rd.

Louisville, KY 40222

Phone: 502-326-9950

health@lfchiro.net

### Acknowledgement of Receipt of Privacy Notice

#### Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR 164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

*Please read the following information carefully:*

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Louisville Family Chiropractic (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.
2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.
3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the above address, Attention: Practice Compliance Director.
4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing. I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): \_\_\_\_\_

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations. By signing this form, I acknowledge that I have reviewed an executed copy of this acknowledgement and a copy of the Practice's Policy Notice and agree to the Practice's use and disclosure of my protected health information for treatment, payment and health care operations.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name (please print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Name of Personal Representative

\_\_\_\_\_  
Relationship to Patient

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To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

Accepted  Denied  Not Applicable  Other (explain) \_\_\_\_\_

\_\_\_\_\_  
Signature of Authorized Practice Representative

\_\_\_\_\_  
Date

**LOUISVILLE FAMILY CHIROPRACTIC**  
**Authorization, Assignment, Consent to Treat and**  
**Medical Release**

In consideration of you undertaking to treat me, I agree to the following:

**MEDICAL RELEASE**

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

**ASSIGNMENT OF BENEFITS**

I authorize the direct payment to you of any sum I now and hereafter owe you by my attorney out of proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign any such company (the pertinent data below) and authorize you to compromise, settle or otherwise resolve this claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will understand that whatever amounts you do not collect from insurance proceeds (whether it be part or all of what is due), I personally owe to you.

**AUTHORIZATION**

I, the undersigned, do hereby appoint Louisville Family Chiropractic, and any of its duly authorized agents, to serve as lawful attorney invested with all powers and authority necessary to endorse and cash any checks, drafts or money orders which are made payable to the undersigned above or as co-payee with Louisville Family Chiropractic when said payments are due for services rendered on behalf of the undersigned by the clinic.

**PREGNANCY RELEASE**

This is to certify that to the best of my knowledge I am not pregnant and that Louisville Family Chiropractic doctor(s) and his/her associates have my permission to perform an x-ray examination. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period \_\_\_/\_\_\_/\_\_\_\_. (initial \_\_\_\_)

**CONSENT TO TREAT**

I, the undersigned, do hereby authorize Louisville Family Chiropractic, (and whomever may be designated as assistants) to administer such examinations, treatments and care, as they deem necessary.

A photocopy of this assignment shall be valid and have the same effect as the original

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Date

Patient's Signature

Witness Signature

# **LOUISVILLE FAMILY CHIROPRACTIC**

## **TERMS OF ACCEPTANCE**

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

**Health:** A state of optimal physical, mental, social well-being, not merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any diseases or condition other than vertebral subluxation. However, it during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_, have read and fully understand the above statements.  
(Patient's name)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date