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:

_____

_____

_____

_____

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? _____

_____

_____

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 paint, 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:

_____

_____

_____

_____

_____

_____

Louisville Family Chiropractic
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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

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

_____

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