ADVANCED CHIROPRACTIC, P.A.

MOTOR VEHICLE ACCIDENT HISTORY

GENERAL INFORMATION

PATIENT NAME:			DATE:
ADDRESS:		CITY:	STATE/ZIP CODE:
HOME PHONE NUMBER:	CELL PHONE NUMBER & PROVIDER:	EMAIL ADDRESS:	
DATE OF BIRTH:	AGE: GENDER:	APPOINTMENT REMINDERS: ❑ TEXT ❑ EMAIL ❑ NO REMINDERS	
INSURANCE COMPANY NAME:	ADJUSTER NAME/PHONE:	CLAIM NUMBER:	

ACCIDENT INFORMATION

DATE OF ACCIDENT:	TIME OF ACCIDENT:	WHERE WERE YOU IN THE VEHICLE DURING THE ACCIDENT? ❑ DRIVER ❑ PASSENGER ❑ FRONT SEAT ❑ BACK SEAT	
NUMBER OF PEOPLE IN THE CAR:	NAMES OF PEOPLE IN THE CAR WITH YOU:		
WHAT DIRECTION WAS YOUR CAR HEADED? ❑ NORTH ❑ SOUTH ❑ EAST ❑ WEST		ON WHAT STEET WERE YOU?:	
WHAT DIRECTION WAS THE OTHER CAR HEADED? ❑ NORTH ❑ SOUTH ❑ EAST ❑ WEST		WERE YOU STRUCK FROM: ❑ BEHIND ❑ FRONT ❑ LEFT SIDE ❑ RIGHT SIDE	
WERE YOU KNOCKED UNCONSCIOUS? ❑ YES ❑ NO	WERE YOU WEARING A SEATBELT? ❑ YES ❑ NO	DID YOU HIT ANY PART OF YOUR BODY? IF SO, EXPLAIN:	
WHERE WERE YOU TAKEN AFTER THE ACCIDENT?			BY AMBULANCE?: ❑ YES ❑ NO
WERE THE POLICE ON SCENE? ❑ YES ❑ NO	WAS A POLICE REPORT FILED? ❑ YES ❑ NO	IF A POLICE REPORT WAS FILED, DO YOU HAVE A COPY? ❑ YES ❑ NO	
ADDITIONAL ACCIDENT DETAILS:			
DESCRIBE THE CHIEF COMPLAINT AND SYMPTOMS OF THE INJURY:			
HAVE YOU BEEN TREATED BY ANY OTHER DOCTORS FOR THIS INJURY/ACCIDENT? ❑ YES ❑ NO		SINCE THE INJURY, ARE YOUR SYMPTOMS: ❑ GETTING BETTER ❑ GETTING WORSE ❑ REMAINING THE SAME	
HAVE YOU LOST TIME FROM WORK? ❑ YES ❑ NO		DATE YOU LEFT WORK:	DATE YOU RETURNED TO WORK:
HAVE YOU BEEN INVOLVED IN AN ACCIDENT IN THE PAST? IF YES, PLEASE DESCRIBE: ❑ YES ❑ NO			
DO YOU HAVE ANY PREVIOUS ILLNESSES WHICH RELATE TO THIS CASE? IF YES, PLEASE DESCRIBE: ❑ YES ❑ NO			
DO YOU HAVE ANY ACTIVITY RESTRICTIONS AS A RESULT OF THIS INJURY? IF YES, PLEASE DESCRIBE: ❑ YES ❑ NO			

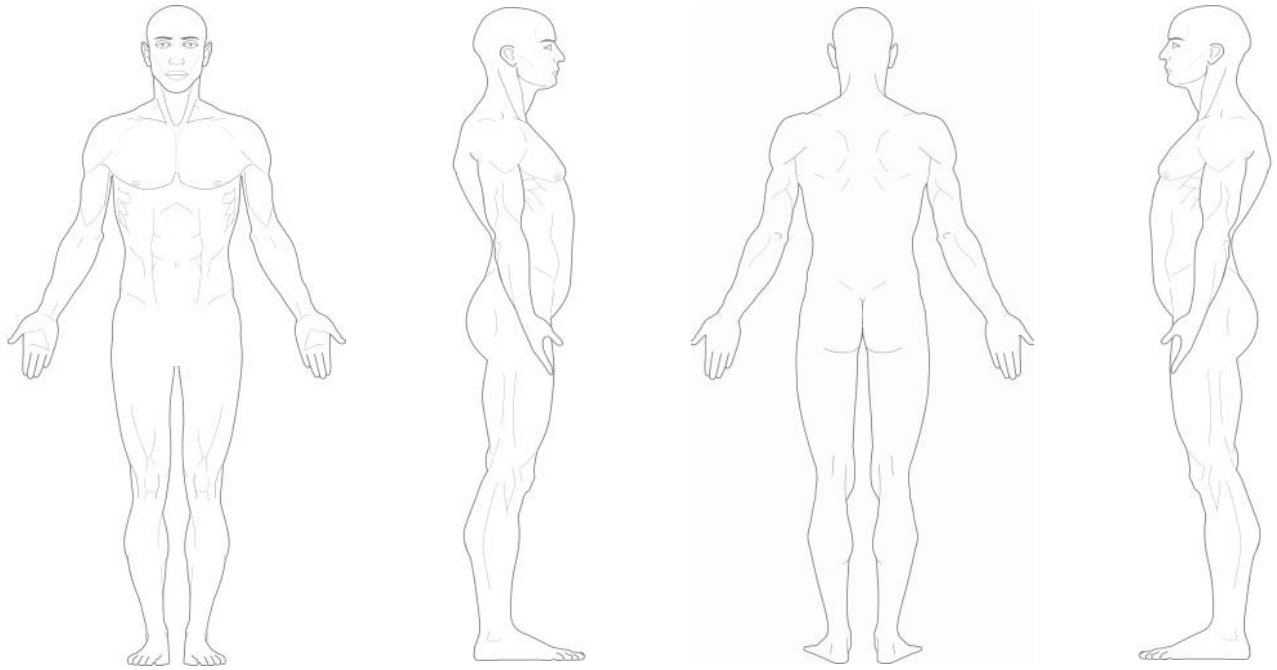
SYMPTOMS

INSTRUCTIONS: *Check (✓) any/all symptoms noted after the accident:*

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

INSTRUCTIONS: *Please mark the area and type of pain on the drawings using the codes listed below:*

N=Numbness P=Pain A=Ache T=Tingling S=Stiffness/Soreness



COMMENTS: _____

_____

_____

_____

SIGNATURE

PATIENT SIGNATURE:	DATE:

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the doctor and associates of Advanced Chiropractic have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

_____ _____

SIGNATURE: DATE:

Advanced Chiropractic, P.A.
2485 Maplewood Drive Suite 215 Maplewood, MN 55109
651-770-7938

Terms of Acceptance

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, 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 a health care provider who specializes in that area. 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 main practice objective is to eliminate and correct the presence of vertebral subluxations and their interference to the body using specific adjustments.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health.

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 adjustments to the spine.

Informed Consent for Chiropractic Spinal Manipulation and Treatment, Authorization and Release

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures and understand that spinal manipulation involves the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also 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, sprains, soreness, and physical therapy burns. I understand and comprehend all such risks and complications. I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy modalities on myself (or on the patient named below whom I am legally responsible) by the licensed doctors of chiropractic of Advanced Chiropractic, P.A. or any doctor, who now or in the future, works as a relief doctor.

I authorize payment of insurance benefits directly to Advanced Chiropractic, P.A. I understand and agree to allow this office to use my Confidential Patient Health Information forms for the purpose of treatment, payment, healthcare operations and coordination of care and authorize Advanced Chiropractic, P.A. to communicate with my medical physician(s) about my condition and treatment. I understand and agree that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I understand that if any payments from my insurance company are sent to me for services rendered at Advanced Chiropractic, P.A, that I am responsible for getting said payments applied to my account and any outstanding charge. I realize that my insurance benefits are a contract/agreement between myself and my insurance company, and Advanced Chiropractic, P.A. is not responsible for quoting medical benefits. Any benefits quoted are just an estimation. I also understand and agree that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

_____ _____

Signature Date

Notice of Privacy Policy

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

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

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

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

I have read and fully understand the Terms of Acceptance and Informed Consent for Chiropractic Spinal Manipulation and Treatment, Authorization and Release. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I have also read and understand the Notice of Privacy Practices and that a more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed. I therefore accept chiropractic care on this basis.

_____	_____
Patient Name *(Please Print)*	Relationship to Patient *(If Patient is a Minor)*
_____	_____
Signature	Date

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