Date: _____
Patient # _____

Automobile Accident History

Last _____ First _____ Middle Initial _____ Birth Date _____ Age _____

Address _____ City _____ ST _____ Zip _____

Phone (H) _____ (W) _____ (C) _____

Email _____ May we send you our online newsletter? ☐yes ☐no

Occupation _____ Employer _____

Spouse's Name _____ Business/Employer _____ Spouse Phone: _____

Who is your primary care physician? _____ Address: _____

Phone: _____ Date of last physical/exam? _____ With Whom? _____

Date of Accident: _____ Time of Accident: _____ am / pm ☐Daylight ☐Dawn ☐Dusk ☐Dark

Road conditions at the time of the accident: ☐Wet ☐Dry ☐Snow ☐Ice ☐Other _____

Was the accident on the job? ☐Yes ☐No Where you in a company vehicle? ☐Yes ☐No

Where were you seated in the vehicle? ☐Driver ☐Passenger ☐Rear-seat ☐Other _____

Were you aware of the approaching collision prior to impact, or did it catch you by surprise? ☐Aware ☐Surprise

Did you lose consciousness upon impact? ☐Yes ☐No Did you experience a flash of light or explosion in your head? ☐Yes ☐No

Did the police come to the accident scene? ☐Yes ☐No Is there a police report? ☐Yes ☐No

Did you go to the hospital? ☐Yes ☐No When? ☐Immediately ☐___hours later ☐___days later Which hospital? _____

How did you get to the hospital? _____ How long did you stay in the hospital? _____

What did the hospital do for your injuries? (collars, splints, x-rays, medication etc.)_____

What areas were x-rayed? _____What was their diagnosis? _____

What did they recommend for follow-up care? _____

Was any other doctor consulted after your accident? ☐Yes ☐No If yes, please complete information below.

Dr. _____ Specialty?_____ Date first seen:_____

Type of treatment:_____ Treatment frequency:_____ How long did you treat?_____

Dr. _____ Specialty?_____ Date first seen:_____

Type of treatment:_____ Treatment frequency:_____ How long did you treat?_____

Were you wearing a seatbelt? ☐Yes ☐No If yes, did you receive any injury or bruise from the seat belt? ☐Yes ☐No

Did your head hit the head rest during the accident? ☐Yes ☐No If adjustable, was the position of the head rest altered? ☐Yes ☐No

Was the seat adjustment altered by the accident? ☐Yes ☐No Was the seat broken by the accident? ☐Yes ☐No

Did the air-bag deploy? ☐Yes ☐No If yes, did it strike you? ☐Yes ☐No If yes, where? _____

Which way was your head pointing at the point of impact? ☐Straight ☐Right ☐Left Body? ☐Straight ☐Right ☐Left

Where were your hands? ☐One on the wheel ☐Both on the wheel ☐Not Applicable

Were you wearing a hat or glasses at the time of impact? ☐Yes ☐No If so, were they still on after the accident? ☐Yes ☐No

YOUR CAR

List the year, make and model of the car you were in: YEAR: _____ MAKE: _____ MODEL: _____

Was your car stopped at the time of impact? ☐Yes ☐No If yes, was the driver's foot on the brake? ☐Yes ☐No If no, estimate the speed of the vehicle you were in: _____mph

If your vehicle was moving at the time of impact, was it: ☐Slowing down ☐Gaining speed ☐Steady speed

THE OTHER CAR

List the year, make and model of the other car : YEAR: _____ MAKE: _____ MODEL: _____

Was the other car moving at the time of impact? ☐Yes ☐No If yes, what was the approximate speed of the vehicle : _____mph

At the time of impact, was the other car: ☐Slowing down ☐Gaining speed ☐Steady speed

Please describe, to the best of your knowledge, what happened during this accident.

_____

_____

_____

_____

_____

_____

You may draw the accident here

AUTOMOBILE INSURANCE INFORMATION

Driver of the automobile you were in: _____ **Name of their auto insurance:** _____

Policy #: _____ **Claim #:** _____

Auto insurance phone #: _____ **Name of insurance adjuster:** _____

Driver of the other vehicle: _____ **Name of their auto insurance:** _____

Policy #: _____ **Claim#:** _____

Auto insurance phone #: _____ **Name of insurance adjuster:** _____

At the time of the accident, did you become or experience any of the following? ☐Confused ☐Disoriented ☐Light headed ☐Dizzy ☐Nauseated ☐Blurred vision ☐Ringing/Buzzing in ears ☐Loss of balance ☐Other: _____

Do you still have any of those symptoms? ☐Yes ☐No **If yes, which ones?** _____

Check symptoms you have noticed since the accident.

☐ Headaches/Migraines	☐ Neck Pain	☐ Upper Back Pain	☐ Shoulder Pain	☐ Midback Pain
☐ Low Back Pain	☐ Depression	☐ Buzzing In Ears	☐ Arm/Leg Pain	☐ Jaw Pain/Clicking
☐ Dizziness	☐ Fatigue	☐ Loss of Memory	☐ Cold Hands/Feet	☐ Numbness/Tingling
☐ Loss of Smell	☐ Irritability	☐ Digestive Problems	☐ Joint Pain/Stiffness	☐ Menstrual Problems
☐ Pinched Nerve	☐ Loss of Sleep	☐ Loss of Balance	☐ Chest Pain	☐ Light Bothers Eyes
☐ Fever	☐ Nervousness	☐ Vision Problems	☐ Urinary Problems	☐ Sleeping Problems
☐ Paralysis	☐ Tension	☐ Fainting	☐ Pins/Needles Feeling	☐ Stomach Upset
☐ Difficulty Swallowing	☐ Sciatica	☐ Sinus Pain	☐ Sore Muscles	☐ Head Feels To Heavy
☐ Other:				

CURRENT COMPLAINTS -List current symptoms separately in order of severity.

1* Body Part: _____

Date symptom first appeared: _____

How often do you experience these symptoms? ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare 10%

What makes symptom increase? _____

What makes symptom decrease? _____

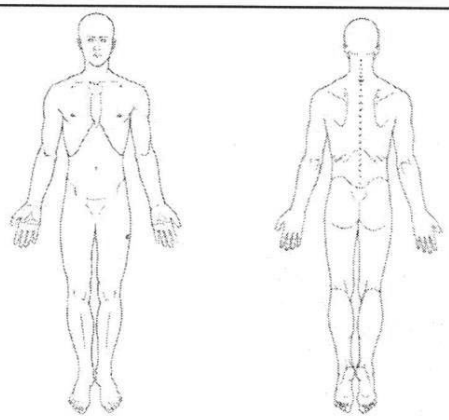
Type of pain? ☐Sharp ☐Dull ☐Aching ☐Burn ☐Throb ☐Numb ☐Other_____

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

0 ◇◇◇ 1 ◇◇◇ 2 ◇◇◇ 3 ◇◇◇ 4 ◇◇◇ 5 ◇◇◇ 6 ◇◇◇ 7 ◇◇◇ 8 ◇◇◇ 9 ◇◇◇ 10

Where does pain radiate to? _____

Please mark areas of pain on the figures below



2* Body Part: _____

Date symptom first appeared: _____

How often do you experience these symptoms? ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare 10%

What makes symptom increase? _____

What makes symptom decrease? _____

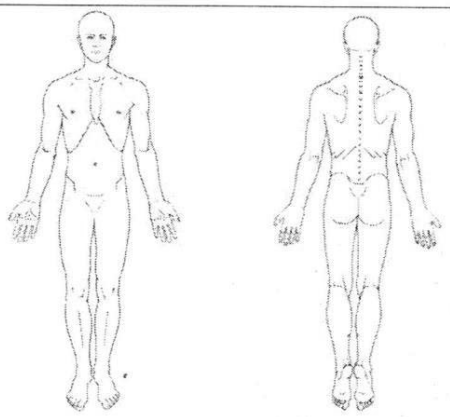
Type of pain? ☐Sharp ☐Dull ☐Aching ☐Burn ☐Throb ☐Numb ☐Other_____

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

0 ◇◇◇ 1 ◇◇◇ 2 ◇◇◇ 3 ◇◇◇ 4 ◇◇◇ 5 ◇◇◇ 6 ◇◇◇ 7 ◇◇◇ 8 ◇◇◇ 9 ◇◇◇ 10

Where does pain radiate to? _____

Please mark areas of pain on the figures below



3* Body Part: _____

Date symptom first appeared: _____

How often do you experience these symptoms? ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare 10%

What makes symptom increase? _____

What makes symptom decrease? _____

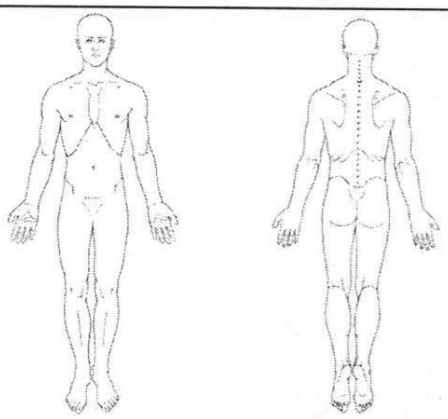
Type of pain? ☐Sharp ☐Dull ☐Aching ☐Burn ☐Throb ☐Numb ☐Other_____

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

0 ◇◇◇ 1 ◇◇◇ 2 ◇◇◇ 3 ◇◇◇ 4 ◇◇◇ 5 ◇◇◇ 6 ◇◇◇ 7 ◇◇◇ 8 ◇◇◇ 9 ◇◇◇ 10

Where does pain radiate to? _____

Please mark areas of pain on the figures below



OCCUPATIONAL INFORMATION

Job involves: ☐Sitting ☐Standing **How long?** _____ ☐Lifting **How much?** _____ ☐Bending ☐Twisting ☐Turning ☐Stooping

Physical activity at work: ☐Sedentary ☐Light manual labor ☐Manual labor ☐Heavy manual labor

Have you missed any time from work due to the accident? ☐Yes ☐No **If yes, how many days?** _____ **Dates:** _____

Are your work activities restricted as a result of this accident? ☐Yes ☐No **If yes, please explain.** _____

Do any of your work activities aggravate your present main complaints? ☐Yes ☐No **If yes, please explain.** _____

_____

Do you smoke? ☐yes ☐no If yes, how many packs per week?_____ **Have you ever smoked in the past?** ☐yes ☐no When did you quit?_____

Do you consume alcohol? ☐yes ☐no If yes, how many drinks per week? _____

Do you consume caffeine? ☐yes ☐no If yes, how many drinks per day? _____

Do you exercise? ☐yes ☐no If yes, how many times per week and what type? _____

Do you have a high stress level? ☐yes ☐no If yes, list reasons:_____

Please list any medications or vitamins you are currently taking (including dosage).

_____ **Frequency:**_____ **Dosage:** _____ **What is this for?** _____

_____ **Frequency:**_____ **Dosage:** _____ **What is this for?** _____

_____ **Frequency:**_____ **Dosage:** _____ **What is this for?** _____

_____ **Frequency:**_____ **Dosage:** _____ **What is this for?** _____

X-RAY CONFIRMATION - FEMALES

At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic pictures if necessary.

_____ _____

Patient Signature **Date**

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.

_____ _____

Patient Signature **Date**

AUTHORIZATION FOR CARE OF MINOR

CONSENT TO TREAT A MINOR: I hearby authorize the doctor(s) at *Discover Chiropractic & Rehabilitation* and whom ever they designate as assistants to administer care to child.

Name of Child / Minor (please print)_____

Name of Parent / Guardian (please print) _____

Parent / Guardian signature: _____ **Date:** _____

CHIROWELL

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc.on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss with the doctor(s) named above and/or with office personnel the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic treatments.

By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

_____
Printed Name of Patient

x_____ _____
Signature of Patient Date

x_____ _____
Signature of Representative (if patient is minor or handicapped) Date

x_____ _____
Witness to Patients' Signature Date

Doctor:_____

CHIROWELL

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $2.50 per digital x-ray or $5.00 per film x-ray and $1.00 per each page, $20.00 administration fee for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr.Jae Chang

Telephone: (480) 485-6655 Fax: (480) 637-7578

Email: livewell@chirowellaz.com

Address: 2501 E Southern Ave. Suite 13, Tempe AZ 85282

Patient Name:_____ **Date:**_____

Patient Signature:_____ **Date:**_____

Assignment of Benefit

Auto Accident Financial Responsibility

Since I was involved in an auto accident/personal injury, I understand my billing will be handled as followed:

1) If I have personal medical insurance, I may authorize CHIROWELL to bill them as I receive my treatment. Some insurance companies require reimbursement after the 3 party has settled; therefore they may not be billed. Others do not require reimbursement, therefore they may be billed. I understand that it's my responsibility to check my policy to see if they require reimbursement.

2) If I have Med-Pay on my auto insurance, I may also authorize to bill them as I receive treatment.

3) If someone else is at fault, I understand their insurance is ultimately responsible for payment, which is called 3 Party insurance. This insurance will not pay until the end of treatment and one-time settlement payment is usually made directly to me for all medical bills and my pain and suffering compensation. I am responsible for paying my bills from this check. If a lien has been filed, both my name and the CHIROWELL 's name will be on the check to ensure both parties receive their payment.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to CHIROWELL for services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize CHIROWELL to release any information including the intake sheets, diagnosis, labs, x-rays, and records of any treatment rendered to me.

I also hereby authorize the release to any appropriate attorney's office and/or healthcare provider to which I may need to be referred to for treatment as a result of this accident. This order will remain in effect until revoked by me in writing.

I have requested medical services from CHIROWELL on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. A photocopy of this assignment is to be considered as valid as the original.

Name:_____ Date:_____

Signature:_____