

Patient's Name: _____ Today's Date: _____

Auto Accident Mechanism of Injury Form

Date of Collision: _____ Hour of Accident: _____ AM / PM

Please describe how the collision happened: _____

Were you wearing a seatbelt? **Yes / No** What type: **Lap Belt / Shoulder Belt / Both**

What was your position in the car? (Circle) **Driver / Front Passenger / Left Rear / Right Rear**

If "Driver", were your hands on the steering wheel? **Both / Left / Right**

What was the year, make and model of vehicle were you in? _____

Direction of Impact: **Front / Back / Left / Right / Other:** _____

What was the year, make and model of the other vehicle? _____

What was the approximate speed of **your vehicle** when the accident occurred? _____ mph

What was the approximate speed of the **other vehicle** when the accident occurred? _____ mph

Did the airbags deploy? **Yes / No**

Were you rendered unconscious as a result of the accident? **Yes / No**

Did you strike another vehicle? **Yes / No** Did another vehicle strike your vehicle? **Yes / No**

If Second Collision – Angle of 2nd impact: **Front / Back / Left / Right / Other:** _____

In relation to the back of your head, was your headrest set: **Low / Middle / High**

Were you surprised by the impact? **Yes / No** If "NO", how did you brace? **With Hands / With Feet**

Where was your head facing at the time of impact? **Straight Ahead/ Left/ Right/ Behind/ Inclined**

Were you leaning forward at the time of impact? **Yes / No**

Did you feel pain immediately after the accident? **Yes / No** If yes, where? _____

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Did you strike anything in the vehicle at the time of impact? **Yes / No** If "YES", specify what part of your body struck what: (i.e. head, chest, chin, shoulder, knee, etc.)

<input type="checkbox"/> Steering Wheel	<input type="checkbox"/> Windshield
<input type="checkbox"/> Dashboard	<input type="checkbox"/> Roof
<input type="checkbox"/> Left Side Door	<input type="checkbox"/> Right Side Door
<input type="checkbox"/> Left Window	<input type="checkbox"/> Right Window
<input type="checkbox"/> Other	

Did your seat break or bend? **Yes / No**

Immediately following the accident, how did you feel? (Circle all that apply) **Dizzy / Dazed / Weak / Upset / Disoriented / Nervous / Nauseous / Other:** _____

Police and Ambulance:

Was the accident reported to the police? **Yes / No**

Were traffic citations issued? **Yes / No** If "YES", to whom? _____

Did you go to the hospital? **Yes / No** If "YES", when? _____

If "YES", how did you get there? **Ambulance / Police Car / Private Transportation**

Were you admitted? **Yes / No** If "YES", how long? _____

Name of Hospital? _____ Attended by Dr. _____

What treatment given? (Circle all that apply) **None / X-rays / Pain Medication / Stitches /**

Muscle Relaxants / Bandaged / Cervical Collar / Physical Therapy / Instructed Regarding

Concussion / Instructed Regarding Sprains & Strains / Instructed to Call an Orthopedist /

Instructed to Call a Private Physician / Referred to This Office / Other: _____

What other doctors have you seen as a result of this injury? _____

Patient Signature

Date

Patient Name: _____ Date: _____

Address _____ City _____ State _____ Zip Code _____

H. Phone _____ W. Phone _____ Cell Phone _____

Email Address: _____ Date of Accident _____

Sex M F Marital Status M S D W Date of Birth _____ Age _____

Occupation _____

Employer _____

Emergency Contact and Phone Number: _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

Name of most recent Chiropractor: _____

1. Since the Motor Vehicle Collision, have you experienced any of the following:

- A. Loss of Range of Motion: yes/no
 - a. What body parts: _____
- B. Visual Disturbance: yes/no blurring l/r floaters l/r vision loss l/r hypersensitivity l/r
 % of time: ___ % of time: ___ % of time: ___ % of time: ___
- C. Dizziness: yes/no % of time: ___
- D. Anxiety/Depression: yes/no % of time: ___
- E. Difficulty Sleeping: yes/no

2. Past Health History:

A. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

B. Previous Injury or Trauma: _____

Have you ever broken any bones? Which? _____

C. Allergies: _____

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3. Family Health History:

Do you have a family history of? (Please indicate all that apply)

- Cancer Strokes/TIA's Headaches Heart disease Neurological diseases
- Adopted/Unknown Cardiac disease below age 40 Psychiatric disease Diabetes
- Other _____ None of the above

A. Deaths in immediate family:

Cause of parents' or siblings' death

Age at death

4. Social and Occupational History:

A. Job description: _____

B. Work schedule: _____

C. Recreational activities: _____

D. Lifestyle:

Hobbies: _____

Level of Exercise: _____

Alcohol Use: _____

Tobacco Use: _____

Drug Use: _____

Diet: _____

5. Medications:

Medication

Reason for taking

Patient Name: _____

Date: _____

Review of Systems

Have you had any of the following pulmonary (lung-related) issues?

- Asthma/difficulty breathing COPD Emphysema Other _____ None of the above

Have you had any of the following cardiovascular (heart-related) issues or procedures?

- Heart surgeries Congestive heart failure Murmurs or valvular disease Heart attacks/MIs Heart disease/problems Hypertension Pacemaker Angina/chest pain Irregular heartbeat Other _____ None of the above

Have you had any of the following neurological (nerve-related) issues?

- Visual changes/loss of vision One-sided weakness of face or body History of seizures One-sided decreased feeling in the face or body Headaches Memory loss Tremors Vertigo Loss of sense of smell Strokes/TIAs Other _____ None of the above

Have you had any of the following endocrine (glandular/hormonal) related issues or procedures?

- Thyroid disease Hormone replacement therapy Injectable steroid replacements Diabetes Other _____ None of the above

Have you had any of the following renal (kidney-related) issues or procedures?

- Renal calculi/stones Hematuria (blood in the urine) Incontinence (can't control) Bladder Infections Difficulty urinating Kidney disease Dialysis Other _____ None of the above

Have you had any of the following gastroenterological (stomach-related) issues?

- Nausea Difficulty swallowing Ulcerative disease Frequent abdominal pain Hiatal hernia Constipation Pancreatic disease Irritable bowel/colitis Hepatitis or liver disease Bloody or black tarry stools Vomiting blood Bowel incontinence Gastroesophageal reflux/heartburn Other _____ None of the above

Have you had any of the following hematological (blood-related) issues?

- Anemia Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) HIV positive Abnormal bleeding/bruising Sickle-cell anemia Enlarged lymph nodes Hemophilia Hypercoagulation or deep venous thrombosis/history of blood clots Anticoagulant therapy Regular aspirin use Other _____ None of the above

Have you had any of the following dermatological (skin-related) issues?

- Significant burns Significant rashes Skin grafts Psoriatic disorders Other _____ None of the above

Have you had any of the following musculoskeletal (bone/muscle-related) issues?

- Rheumatoid arthritis Gout Osteoarthritis Broken bones Spinal fracture Spinal surgery Joint surgery Arthritis (unknown type) Scoliosis Metal implants Other _____ None of the above

Have you had any of the following psychological issues?

- Psychiatric diagnosis Depression Suicidal ideations Bipolar disorder Homicidal ideations Schizophrenia Psychiatric hospitalizations Other _____ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Babcock Chiropractic Clinic for services performed.

Patient or Guardian Signature _____

Date _____

Patient Name: _____

Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature of Patient or Representative

Date

Printed Name

Patient Name: _____

Date: _____

NEW PATIENT HISTORY FORM

Symptom 1 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)
 - **Did you have this symptom before this motor vehicle collision?** Yes/No (circle one)
If yes, what was the intensity (1-10 w/10 the worst) ____ and frequency (%) ____ prior to the collision?
- What makes the symptom worse? (circle all that apply):
 - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?

<ul style="list-style-type: none"> ○ No ○ Anti-inflammatory meds ○ Pain medication ○ Muscle relaxers ○ Trigger point injections ○ Cortisone injections 	<ul style="list-style-type: none"> ○ Surgery ○ Massage ○ Physical Therapy ○ Chiropractic ○ Cortisone Injection ○ Other _____
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Patient Name: _____

Date: _____

NEW PATIENT HISTORY FORM

Symptom 2 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)
 - **Did you have this symptom before this motor vehicle collision?** Yes/No (circle one)
If yes, what was the intensity (1-10 w/10 the worst) ____ and frequency (%) ____ prior to the collision?
- What makes the symptom worse? (circle all that apply):
 - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?

<ul style="list-style-type: none"> ○ No ○ Anti-inflammatory meds ○ Pain medication ○ Muscle relaxers ○ Trigger point injections ○ Cortisone injections 	<ul style="list-style-type: none"> ○ Surgery ○ Massage ○ Physical Therapy ○ Chiropractic ○ Cortisone Injection ○ Other _____
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Patient Name: _____

Date: _____

NEW PATIENT HISTORY FORM

Symptom 3 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)
 - **Did you have this symptom before this motor vehicle collision?** Yes/No (circle one)
If yes, what was the intensity (1-10 w/10 the worst) ____ and frequency (%) ____ prior to the collision?
- What makes the symptom worse? (circle all that apply):
 - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?

<ul style="list-style-type: none"> ○ No ○ Anti-inflammatory meds ○ Pain medication ○ Muscle relaxers ○ Trigger point injections ○ Cortisone injections ○ 	<ul style="list-style-type: none"> ○ Surgery ○ Massage ○ Physical Therapy ○ Chiropractic ○ Cortisone Injection ○ Other _____
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Patient Name: _____

Date: _____

NEW PATIENT HISTORY FORM

Symptom 4 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)
 - **Did you have this symptom before this motor vehicle collision?** Yes/No (circle one)
If yes, what was the intensity (1-10 w/10 the worst) ____ and frequency (%) ____ prior to the collision?
- What makes the symptom worse? (circle all that apply):
 - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?

<ul style="list-style-type: none"> ○ No ○ Anti-inflammatory meds ○ Pain medication ○ Muscle relaxers ○ Trigger point injections ○ Cortisone injections 	<ul style="list-style-type: none"> ○ Surgery ○ Massage ○ Physical Therapy ○ Chiropractic ○ Cortisone Injection ○ Other _____ ○
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