intouchchiropractic

# PERSONAL INJURY QUESTIONNAIRE

Today's Date:_____ Referred By:_____

Patient Name:_____ Male Female File#_____

Social Security Number:_____ Age:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Cell:_____ Home:_____ Work: _____

Email:_____ Marital Status: S M W D

Spouse's Name:_____ Name(s) of Kids:_____

Employer:_____ Occupation:_____

Emergency Contact:_____ Phone Number:_____

Appointment Reminders: oEmail oText (Cell Phone Carrier: _____)

Previous Chiropractors:_____ Height:_____ Weight:_____

List Any Surgeries with Dates:_____

List Medications Prior to Accident:_____

**If you have medical payments on your own personal automobile insurance policy OR have contracted an attorney, we can bill the responsible insurance company directly. For all other third party claims, please make payment at the time of service. I authorize Intouch Chiropractic to render necessary services to me and I am responsible for all charges incurred at the time of service.**

Patient/Guardian Signature:_____ Date:_____

## NATURE OF ACCIDENT

Date of Accident:_____ Time of Day:_____

Were You: Driver Passenger Front Seat Back Seat

Number of People in the Vehicle:_____ Were You Wearing Seatbelts? Yes No

What Direction Were You Headed? North East South West Name of Street:_____

What Direction Was Other Vehicle Headed? North East South West Name of Street:_____

Were You Struck From: Behind Front Left Side Right Side

Approximate Speed of Your Car:_____mph Other Car:_____mph

Were You Knocked Unconscious? Yes No If Yes, For How Long?_____

Were Police Notified? Yes No Police Report? Yes No

Were there any witnesses? Yes No Name and Phone Number:_____

Please Describe the Accident:_____

_____

Did You Have Any Physical Complaints BEFORE THE ACCIDENT? Yes No
Describe_____

Please Describe How You Felt:

DURING the Accident:_____

IMMEDIATELY AFTER the Accident:_____

LATER THAT DAY:_____

THE NEXT DAY:_____

What Are Your Present Complaints and Symptoms?_____

_____

Medications Taken SINCE the Accident _____

Do You Have Any Congenital (From Birth) Factors, Which Relate To Your Symptoms? Yes No
Describe_____

Do You Have Any Previous Illnesses Which Relate to This Case? Yes No
Describe_____

Have You Ever Been Involved in an Accident Before? Yes No
Describe, Dates, Types of Accidents, Treatments Received:_____

_____

Where Were You Taken After the Current Accident?_____

Have You Been Treated by Another Doctor Since the Current Accident? Yes No
List Doctor's Name, Specialty, Phone Number:_____
What Type of Treatment Did You Receive?_____

Since This Injury Occurred, Are Your Symptoms: Improving Getting Worse Same

**CIRCLE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:**

| | | | |
|---|---|---|---|
| Neck Pain/Stiffness | Low Back Pain | Pain, Right Shoulder | Pain, Right Fingers |
| Neck Muscle Spasm | Sciatica, Right Side | Pain, Left Shoulder | Pain, Left Fingers |
| Numbness in Shoulders | Sciatica, Left Side | Pain, Right Elbow | Pain, Right Hip |
| Numbness in Arms | Numbness, Right Leg | Pain, Left Elbow | Pain, Left Hip |
| Numbness in Hands | Numbness, Left Leg | Pain, Right Forearm | Pain, Right Knee |
| Midback Pain | Numbness, Right Toes | Pain, Left Forearm | Pain, Left Knee |
| Numbness in Midback | Numbness, Left Toes | Pain, Right Wrist | Pain, Right Ankle/foot |
| Midback Muscle Spasm | Sleeping Problems | Pain, Left Wrist | Pain, Left Ankle/Foot |
| Rib Pain/Sprain | Abnormal Posture | Pain, Right Hand | Headaches |
| Dizziness/Vertigo | Difficulty Walking | Pain, Left Hand | Muscle weakness |
| Loss of Taste | Loss of Balance | Loss of Smell | Loss of Memory |
| Upset Stomach | Irritability/Nervousness | Buzz/Ringing in Ears | Constipation/Diarrhea |

Have You Lost Time From Work As a Result of This Accident? Yes No If Yes, Please Complete This Question.

Last Day Worked:_____ Type of Employment:_____

Are You Being Compensated For Time Lost From Work? Yes No
Describe_____

Do You Notice Any Daily Activity Restrictions As a Result of This Injury? Yes No
Describe_____

Other Pertinent Information:_____

## Patient Consent to Physical Examination and X-Rays

Prior to receiving chiropractic care in this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed before treatment. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan to help you become healthier prior to beginning care.

During your examination, the doctor may determine that x-rays will be needed. In order to perform x-rays on any patient, our office requires the patient's consent for such tests.

I understand that the doctor may need x-rays in order to diagnose my condition and I give permission of all needed diagnostic tests, x-rays and physical examinations.

**Patient/Guardian Signature: _____ Date: _____**

## Females Only: Regarding Possibility of Pregnancy

I understand that x-rays may be needed at some point and that by signature on this form, I do hereby state that to the best of my knowledge, I am not pregnant. It is neither suspected nor confirmed at this particular time that I am pregnant. If determined at a later date that I am pregnant, I do not hold the doctor, health care provider's associates, association, corporation, partnership, employees, agents and estate of this establishment accountable in any way.

**Patient/Guardian Signature: _____ Date: _____**

## Medical Insurance Information/Financial Responsibility

I hereby instruct and direct _____ Insurance Company to pay by check or EFT any insurance benefit payments to: Intouch Chiropractic, 2425 Camino Del Rio South #100, San Diego, CA 92108

**In the event that a check(s) is/are mailed to me, or if my current policy prohibits direct payment to doctor, I understand that I am responsible for bringing the check(s) into the office within 7 days so that my account can be properly credited.**

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I also authorize the request of medical records, reports and imaging which are pertinent to the delivery of my care by this office. I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Intouch Chiropractic provides its services directly to you, not your insurance company. I have read and understand that I am ultimately liable for my bill.

**Patient Name:_____** **Date:_____**

**_____** **Witness: _____**

**Signature of Policyholder/Claimant, if other than Policyholder**

## Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include temporary soreness, sprain/strain injuries, irritation of a disc condition, and rarely fractures and dislocations. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there may be a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. There may be problems or complications that might arise from chiropractic treatment, other than those described herein. These “other problems or complications” occur so infrequently that it is not possible to anticipate them, predict them or explain them all in advance of starting treatment. If any problem starts to develop, please advise the doctor.

I understand and accept that there are risks associated with chiropractic care and give my consent to the treatment that the doctor deems necessary, and to the chiropractic care including spinal adjustments and other modalities, as reported following my assessment.

**Patient/Guardian Signature: _____** **Date: _____**

**Witness: _____**

## Consent for Treatment of Minors

I, being parent or guardian of _____, a minor the age of _____, do hereby authorize, request and direct Dr. Devin Young D.C. and/or Dr. Jeanett Tapia D.C. to perform an exam, x-ray and chiropractic treatment for their condition as he/she deems necessary. In addition, I give permission for the doctors to manage his/her care when I am not present to observe such care.

**Patient/Guardian Signature: _____** **Date: _____**

Witness: _____

## Authorization for Care/Terms of Acceptance

I hereby authorize the doctor and whomever they may designate as their assistant to administer chiropractic care, to work with my condition through the use of adjustments and procedures the doctor deems appropriate. The doctor will not be held responsible for any preexisting medically diagnosed conditions nor for any medical diagnosis.
When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working toward the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

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 to the spine.

Health is a state of optimal physical, mental and social well-being not merely the absence of disease.

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

We do not offer to diagnose or treat any disease or condition other than the 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. We do not and cannot promise or guarantee to cure any specific symptom, disease or condition. 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 subluxation.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.
I agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

**Patient/Guardian Signature: _____ Date:_____**

## Patient Consent for Use & Disclosure of Protected Health Information

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 healthcare providers who may be involved directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

We use an 'open adjusting' area. If at any time you prefer or need a 'closed' adjusting area, or would like to discuss your health in the privacy of a closed room, please communicate this to a member of our staff. I have read and understand your Notice of Privacy Practices. 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.

**Patient/Guardian Signature: _____ Date:_____**

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# PERSONAL INJURY PAYMENT POLICY

## Who Was At-Fault?:

_____ I was at-fault for the accident

_____ Another person was at-fault for the accident

## Medical Payments:

_____ I have medical payments on my OWN auto insurance policy $_____max limits

_____ I do not have medical payments on my OWN auto insurance policy

## Attorney Information:

_____ I have contracted an attorney

_____ I have not contracted an attorney

Attorney's Name:_____ Phone#:_____

Fax#:_____

## Your Auto Insurance Information (not personal medical insurance)

Your Name:_____

Your Insurance Company:_____ Claim#:_____

Adjustor's Name:_____ Phone#:_____

Address: _____ Fax#:_____

Date of Accident:_____

## Other Driver's Insurance Information

Other Driver's Name:_____

Other Driver's Insurance Company:_____ Claim#:_____

Adjustor's Name:_____ Phone#:_____

Address: _____ Fax#:_____

**If you have medical payments on your own personal automobile insurance policy <u>OR</u> have contracted an attorney, we can bill the responsible insurance company directly. For all other third party claims, please make payment at the time of service. I authorize Intouch Chiropractic to render necessary services to me and I am responsible for all charges incurred at the time of service.**

Patient/Guardian Signature:_____ Date:_____