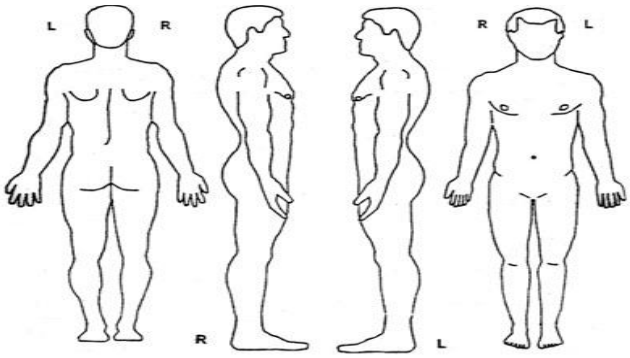
ALVIS CHIROPRACTIC-Motor Vehicle Accident

Name:_____**Birthdate**:_____Age:_____**Phone#:**_____
Full Address:_____ZIP:_____Email:_____
Employer: _____Work Address:_____Occupation:_____
Marital Status: □Single □Married Spouse Name: _____Spouse Phone:_____# of Children:___
Preferred form of contact for you: □Phone Call (___)____-_____ □TEXT to (____)____-_____ □Email (above)
Emergency Contact: □Spouse □Other:_____Phone #:_____
Who is responsible for payment? □Self □Spouse □Other_____

YOUR Auto Insurance claim info:
Insurance Co:_____
Claim#:_____
Adjuster Name:_____
Adjuster Phone: _____
Have you completed and submitted your Medical/PIP application to your auto insurance company? Yes No

How did you learn of ALVIS Chiropractic?_____

Indicate on the drawings where you have pain/symptoms►



How would you describe the type of pain? (Check all that apply)
□Sharp □Stabbing □Burning □Achy □Dull □Stiff & Sore
□Numbness □Tingling □Weakness
□Radiating Pain: if yes indicate where: _____

How often do you experience your symptoms?
□ Intermittently (1-25% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Constantly (76-100% of the time)

Average Pain Intensity: (circle appropriate number)

Last 24 hours:	0	1	2	3	4	5	6	7	8	9	10
Past Week:	0	1	2	3	4	5	6	7	8	9	10

What makes it better? □Ice □Heat □Rest □Movement □Stretching □OTC □Other_____
What makes it worse? □Sit □Stand □Walk □Lying □Sleep □Overuse □Other_____

HEADACHES: □No □Yes If Yes; FREQUENCY: ___#per Day ___#per Week ___#per Month
Average INTENSITY (circle one): 0 1 2 3 4 5 6 7 8 9 10

Your Height: ____ _____ Weight: ____

Other Doctor(s)/providers seen for these injuries:_____

Prior to this accident, have you ever experienced similar injuries/pain/symptoms? Yes No
If yes, please explain_____

What concerns you most about your injuries?_____

How much have your symptoms interfered with your usual daily activities?
□Not at all □A little bit □Moderately □Quite a bit □Extremely

What activities do you do at work?	Activity:	A little of the day	Half the day	Most of the day
	Sit	□	□	□
	Stand	□	□	□
	Computer work	□	□	□
	On the Phone	□	□	□

Has the problem interfered with your work? □None □A little bit □Moderately □Quite a bit □Extremely

What activities do you do outside of work?_____

What activities does your condition prevent you from doing?_____

How do you rate your overall health? □Poor □Fair □ Good □Very Good □Excellent

What level of exercise do you do? □None □Light □Moderate □Strenuous

Indicate if any *immediate* family members have any of the following:
□Rheumatoid Arthritis □Diabetes □Lupus □Heart Problems □Cancer □ALS(Lou Gehrig's Disease)

For each of the conditions below, indicate Past or Present condition by an "X" in the box.

Past	Present	Past	Present	Past	Present
□	□Headaches	□	□High Blood Pressure	□	□Diabetes
□	□Neck Pain	□	□Heart Attack	□	□Excessive Thirst
□	□Upper Back Pain	□	□Chest Pains	□	□Frequent Urination
□	□Mid Back Pain	□	□Stroke	□	□Smoking/Tobacco Use
□	□Low Back Pain	□	□Angina	□	□Allergies
□	□Shoulder Pain	□	□Kidney Stones	□	□Depression
□	□Elbow/Upper Arm Pain	□	□Kidney Disorders	□	□Systemic Lupus
□	□Wrist Pain	□	□Bladder Infection	□	□Epilepsy
□	□Hand Pain	□	□Painful Urination	□	□Dermatitis/Eczema/Rash
□	□Hip Pain	□	□Loss of Bladder Control	□	□HIV/AIDS
□	□Upper Leg Pain	□	□Prostate Problems		
□	□Knee Pain	□	□Abnormal Weight Gain/Loss		
□	□Ankle/Foot Pain	□	□Loss of Appetite		
□	□Jaw Pain	□	□Abdominal Pain	**Females ONLY**	
□	□Joint Pain/Stiffness	□	□Ulcer	□	□Birth Control Pill
□	□Arthritis	□	□Hepatitis	□	□Hormone Replacement
□	□Rheumatoid Arthritis	□	□Liver/Gall Bladder Disorder	□	□Pregnancy
□	□Cancer	□	□General Fatigue		
□	□Tumor	□	□Muscular Incoordination		
□	□Asthma	□	□Visual Disturbances		
□	□Chronic Sinusitis	□	□Dizziness		

List all *presciption* medications you are currently taking:_____

List all *over-the-counter* medications you are currently taking:_____

Have you ever been hospitalized & Why?_____

List all surgical procedures you have had:_____

Is there anything else pertinent to your visit today?_____

Financial Agreement

I understand and agree that my insurance policies are a contract between my insurance carrier and me. I understand and agree that I am financially responsible for payment of all services rendered by ALVIS Chiropractic to me. I understand that ALVIS Chiropractic will prepare necessary reports and forms to assist me in making collection from my insurance company and that any payments made to ALVIS Chiropractic will be credited to my account upon receipt. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Consent of Professional Services and Release of Information

I hereby authorize the doctor and whomever he may designate as his assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he deems necessary in any case; and I further authorize him to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

Privacy Notice Review

I have been provided a copy of the ALVIS CHIROPRACTIC Privacy Notice for review and I understand that I can ask questions about the privacy practices at any time. In addition, I understand I can request a copy of the ALVIS CHIROPRACTIC Privacy Notice at any time.

Signature: _____Date:_____

Doctor's Signature _____ Date Reviewed: _____

For info on HIPPA Privacy Act: www.hhs.gov/ocr/hipaa/privacy