LyonsHealth LLC
Chiropractic & Wellness Associates
2920 S. Webster Ave., Suite 100, Green Bay, WI 54301
(920) 347-4884

Personal Injury / Accident Medical History Intake Form

Please allow our staff to photocopy your driver's license and accident information exchange card
PLEASE PRINT CLEARLY

Full Name_____

Email_____ Gender M F Age: _____ Birth Date:_____

Address_____City_____ State_____Zip_____

Social Security #_____ Home Phone (_____)_____ Cell phone (____) _____

Name of Spouse, Parent or Guardian _____Age _____ BirthDate_____ SS#_____

Females: Are you or is there a possibility that you may be pregnant? ____ Y/N

Employer_____ Occupation_____ Wk Phone_____

In case of emergency contact_____Relationship_____ _____

Phone Number (___)_____ Cell (___)_____ Wk Phone (____)_____

Insurance/Attorney Information

Do you have Med Pay? Y N

Insurance Company of the Person **at Fault** _____ **Name of Agent:** _____

Insurance Company Address: _____City_____St_____Zip_____

Accident Information
Date of Accident ____/____/_____ **Time of Accident**_____ am pm **Location of accident** _____
Your Vehicle: Year _____ Make_____
Model_____ **Your Speed** _____
Other Vehicle: Year _____ Make _____ Model _____ **Their Speed** _____
Accident Type: Rear ended Head-on Broad-sided **Damage to Your Vehicle** $_____ **Other Vehicle** $_____

Describe Accident_____

_____

What was your position in the vehicle? ____ Driver ____Passenger

Who hit who? ____you were struck ____struck another vehicle

What was your vehicle's point of impact? _____ What was the *other* vehicle's point of impact? _____

What happened to your body at moment of impact? ____thrown back and forth _____thrown side to side

Where you wearing seat restraints? ____Y/N

What position were your vehicles head rest in? ____lowest position ____middle position ____highest position

Were you prepared for the impact?

____was completely surprised ___saw the collision coming ____saw the collision coming and braced accordingly

What position was your body in just prior to impact?

____straight ahead ____rotated left ____rotated right ____can't remember

What was your mental/emotional state immediately following the accident?

____was not rendered unconscious ____was not rendered unconscious but was shaken up and disoriented ____was rendered unconscious

Did you receive medical attention at the scene of the accident? ____Y/N

Where did you go immediately after the accident? ____hospital ____home ____resumed daily activities

Symptomatology (Pain Characteristics for Major Area of Complaint)

The pain started

_____

_____

The pain is made better by

_____

and worse by

_____

The pain has the following qualities

_____

___There is ___There is not radiation into

_____

___ There is ___There is not referred pain into

_____

___ There is ___There is not parasthesia (tingling/numbness) into

_____

The pain is located

_____

The pain is (as far as timing is concerned: i.e. comes & goes, constant, etc.)

_____

Indicate the symptoms that are a result of this accident:

DIZZINESS	**DIFFICULTY SLEEPING**	**JAW PROBLEMS**	**NAUSEA**
MEMORY LOSS	**ARM/SHOULDER PAIN**	**IRRITABLITY**	**BACK PAIN**
HEADACHE(S)	**NUMB HANDS/FINGERS**	**FATIGUE**	**LOW BACK PAIN**
BLURRED VISION	**TENSION**	**CHEST PAIN**	**BACK STIFFNESS**
BUZZING IN EAR	**NECK PAIN**	**SHORT BREATH**	**LEG PAIN**
EARS RINGING	**STIFF NECK**	**STOMACH UPSET**	**NUMB FEET/TOES**

OTHER_____

_____

<u>Daily Activities Pain Rating</u>

How many days out of an average week do you have pain? _____ **On a scale of 1-10, rate your pain**

No Pain Severe Pain

How much time out of an average day are you in pain? _____ 0 1 2 3 4 5 6 7 8 9 10

What are the worst times of day for the pain? _____ **Describe the overall severity of the pain**

___ Mild Nuisance

What are the best times of the day for the pain?_____ ___ Mild to moderate but can live with it___Moderate, having trouble coping with

How do the following activities affect your pain? ___Severe, it is ruining my quality of life

	No Change	Relieves	Increased	Duration
Sitting	___	___	___	_____
Walking	___	___	___	_____
Standing	___	___	___	_____
Lying Down	___	___	___	_____
Looking Up	___	___	___	_____
Looking Down	___	___	___	_____
Lifting	___	___	___	_____

Progression: How is your pain compared to when the pain episode first started?

___Much improved ___Much worse

___A little worse ___No Change

___Somewhat improved

What do you do to relieve the pain?

_____

_____

_____

What are some recreational activities that participated in before this current problem and which ones cannot be performed now to
the same extent.

Please mark each that apply to your Daily Activities due to your problem:

__Has difficulty climbing stairs ___Changes position frequently to try and get comfortable ___Has a loss of appetite
___Walks more slowly than normal ___Stays in bed most of the day ___Has difficulty sleeping
___Does not do jobs around the house ___Has to use handrails to get up stairs, etc. ___Can only walk short distances
___Has to lie down and rest frequently ___Has to hold onto something to sit or stand from a chair
___Has to sit most of the day
___Has to get other people to do things for you ___Has difficulty getting dressed due to problem
___Has difficulty bending
___Has become more irritable ___Has difficulty turning over in bed
___Has to get dressed with someone's help

How often do you have to stop activites and sit or lie down to control your symptoms?
___ Several times a day ___Occasionally ___Approximately once per day ___Never ___All Day

Social History: ___Single ___Married ___Divorced ___# of Children ___Smoker ___Non-Smoker ___Drink Alcohol ___Takes Drugs
___Does not drink Alcohol ___Does not take drugs

Occupational History

Your Employer _____ **What is your current job satisfaction?**
Job Title _____ ___Very Satisfied ___Satisfied ___Dissatisfied ___Very Dissatisfied
Are your Job Duties physically demanding for you? Y N **Have you had any disability time?** Y N
If you are currently working which are you performing? ___Regular Duties ___Limited – Light Duties

Medical History

List the Physicians and other practitioners you have seen for this problem: List the Medications you are currently taking:

_____
_____
_____
_____
_____ **List the treatments you have had for your problem List the types of Diagnostic Testing for this problem**

___Hot packs ___ Ultrasound ___Chiropractic ___X-rays ___CT Scan ___Myelogram ___MRI Scan
___Massage ___Osteopathy ___Electrical Stimulation (EMS) ___Discogram ___Bone Scan ___EMG
___TENS Unit ___Trigger Point Injections
___Epidural Injections
___Strengthening Exercises ___Back Brace ___Aerobics
___Acupuncture ___ Traction ___Naturopathy ___Bed Rest

List Past Surgeries: ___None **List Past Hospitalizations:** ___None

_____
_____
_____

List previous back, neck and musculoskeletal problems

_____

Medical History

Mark if you have had any of the following symptoms in the past 5 years

___Unexplained fevers ___Swollen ankles
___Night Sweats ___Stomach pain
___Weight loss of 10 lbs or more ___Change in bowel habits
___Loss of appetite ___Persistent diarrhea
___Excessive fatigue ___Excessive constipation
___Problems with depression ___Dark black stools
___Unusual stress at work ___Pain–burning when urinating
___Easy Bruising ___Difficulty urinating – start/stop
___Excessive bleeding ___Need to urinate more at night
___Lumps in neck, armpit or groin ___Morning stiffness
___Chest pain or tightness ___Persistent eye redness
___Persistent or unusual cough ___Muscle tenderness
___Trouble breathing with exercise ___Dry eyes or mouth
___Trouble breathing lying flat ___Skin rashes
___Coughing up blood ___Joint pain or swelling

NOTES:

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those
records. In addition to how your PHI will be used, office policies regarding payment and collections, and consent to treat are
listed below. By signing at the end of these policies, you agree to all stipulations.

1. The patient understands and agrees to allow Lyons Health LLC to use their PHI for the purpose of treatment payment, health care operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections.
The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A Patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Lyons Health LLC to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care

.

AUTHORIZATIONS, ASSIGNMETNS OF BENEFITS AND CONSENT TO TREAT

To: Lyons Health LLC Doctors, hereafter referred to as OFFICE

1. I authorize, assign and direct my insurance carrier, to pay directly to said OFFICE such sums as may be due and owing the OFFICE of services rendered me, now or hereafter, which are payable under my insurance contract, or contractual agreement.

2. Patient agrees, that in the event patient receives any checks, drafts or other payment subject to this agreement, patient agrees to act as fiduciary agent to the OFFICE. The OFFICE agrees to apply any proceeds to the patient's debt for services rendered.
3. I fully understand and agree insurance policies are an arrangement between the insurance carrier and myself. I will be responsible for expenses not paid by insurance. I understand and agree that either health insurance or automobile insurance may not pay all of the charges of the OFFICE for my treatment. I understand and agree to pay the customary charges of the OFFICE and agree that if my health insurance or automobile insurance does not pay for my treatment in full, I will be responsible for the remaining balance. I understand and agree that I will be charged for missed appointments and that it may be necessary for OFFICE to record a lien on my case to ensure payment. I agree to pay the charges associated with filing of the lien.
4. I understand that if necessary of OFFICE to employ collection counsel and/or an attorney on my bill, I the patient will be responsible for any said collection and/or attorney fees.
5. I agree the OFFICE has the right to call my home or place of employment regarding appointment or insurance issues.
6. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including nutritional assessment and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic and/or licensed doctors of chiropractic who now or in the future treat me while employed by, or are associated with or serving as back-up for the doctor of chiropractic, including those working at the clinic or office or any other office or clinic.
7. I 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, disk injuries, strokes, dislocations and sprains. I do expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, is in my best interests.
8. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) I seek treatment.
9. A photocopy of this form shall be as valid as original

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____

Patient's signature Date

_____ _____

Legal guardian if patient is a minor Relationship to minor