Patient Intake: AUTO (1)

Date Today: _____

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Dominant Hand: ☐ Right ☐ Left ☐ Male ☐ Female

Home Address _____ City, State, Zip _____

Phone (cell): _____ Phone (other): _____

Email: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ D.P SSN: _____

Your Car Insurance Company _____

Address _____ City, State, Zip _____

Adjuster _____ Phone _____

Agent _____ Phone _____

Policy # _____ Claim # _____

Amount medical payments coverage? _____ Amount uninsured motorist coverage? _____

Name of Other Driver Involved _____

Other Driver's Insurance Company _____

Policy # _____ Claim # _____

What law firm represents you? _____

Address _____ City, State, Zip _____

Your lawyer's name? _____ Phone _____

Date of loss/crash? _____ Date you first saw doctor after crash _____

Cost of all medical treatment since the crash? $ _____

How much income have you lost since the crash? $ _____

What is the property damage (repair amount) of your car? $ _____

Name of your personal M.D. _____ Phone _____

HABITS Smoke: ☐ No ☐ Yes: Pk/day _____ Years _____

Alcohol: ☐ Never ☐ Social ☐ Light ☐ Moderate ☐ Heavy

EMPLOYMENT

Occupation/job at time of crash: _____

Employer: _____ ☐ Unemployed

Occupation/job currently: _____

Employer: _____ Unemployed, due to crash? ☐ Yes ☐ No

Type of work: ☐ Office/clerical ☐ Light labor ☐ Moderate labor ☐ Heavy labor

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Patient Intake: AUTO (2)

MEDICAL HISTORY

Surgeries (dates and residuals): _____

Fractures (dates and residuals): _____

Serious illness (dates and residuals): _____

Workers' comp. injuries (date, TX, awards, residuals): _____

Personal injuries (date, TX, awards, residuals): _____

Sports or other injuries to head, neck, or back: _____

Any episodes of current complaints: _____

1. _____

2. _____

3. _____

INJURY HISTORY

Date of crash injury(ies): _____ Were you aware of the coming crash? ☐ Yes ☐ No

Was the crash on-the-job? ☐ Yes ☐ No

You were the: ☐ Driver ☐ Passenger – Front ☐ Passenger – Rear L / R

☐ Motorcycle-operator ☐ Motorcycle-passenger ☐ Other _____

Vehicle driven by (name): _____

YOUR vehicle (year, make, model): _____

Does it have a trailer hitch? ☐ Yes ☐ No ☐ Not sure

Your estimated speed at moment of crash: _____ ☐ Stopped ☐ Slowing ☐ Accelerating

OTHER vehicle (year, make, model): _____

Road conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Icy ☐ Other _____

Your head restraint: ☐ None ☐ Integral ☐ Adjustable: up / down ☐ Don't know

Was your seat back position altered by the crash? ☐ Yes ☐ No

Was the seat broken? ☐ Yes ☐ No

Were you wearing a lap belt? ☐ Yes ☐ No Shoulder belt? ☐ Yes ☐ No

Did air bag deploy? ☐ Yes ☐ No If yes, were you struck by it? ☐ Yes ☐ No

Body position: ☐ Straight forward ☐ Leaning forward Twisted Other

Head position: ☐ Forward ☐ Left _____ ° ☐ Right _____ ° ☐ Up _____ ° ☐ Down _____ °

Hands: ☐ One (☐ L or ☐ R) on wheel ☐ Two on wheel ☐ Not sure ☐ Not driving

Brakes applied? ☐ Yes ☐ No ☐ Not sure

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Patient Intake: AUTO (3)

DURING THE CRASH

Location of crash (street, intersection, city, state): _____

_____

Damage to your vehicle: ☐ Front ☐ Rear ☐ Driver side ☐ Passenger side ☐ Roof ☐ Other _____

Estimated damage to your vehicle: $ _____ ☐ Not yet estimated.

Did your body strike any parts of the vehicle? ☐ No ☐ Yes, describe: _____

_____

Did your vehicle strike any other objects after crash? ☐ No ☐ Yes, describe: _____

_____

Were police on-scene? ☐ No ☐ Yes. If yes, was a report made? ☐ No ☐ Yes

AFTER THE CRASH

Symptoms of: ☐ Headache ☐ Dizziness ☐ Nausea ☐ Confusion/disorientation ☐ Neck pain ☐ Back pain

☐ Numbness/tingling/paresthesia(s) If yes, where? _____

☐ Arm and/or leg pain. If yes, where? _____

☐ Other symptoms: _____

Where did you go after crash?

☐ Home ☐ Work ☐ Hospital _____ ☐ Private Doctor _____

Mode of transportation: ☐ Drove self ☐ Other drove ☐ Emergency transport

TREATMENT HISTORY

Prior to this office, have you been evaluated/treated for these injuries? ☐ No ☐ Yes (list below)

Date: _____ Doctor/Provider: _____

Specialty: _____

Treatment: _____

Date: _____ Doctor/Provider: _____

Specialty: _____

Treatment: _____

Date: _____ Doctor/Provider: _____

Specialty: _____

Treatment: _____

Date: _____ Doctor/Provider: _____

Specialty: _____

Treatment: _____

_____ If more space is needed, let the doctor know.

_____ DOCTOR ONLY _____

Request records:

☐ Request radiographs from:

☐ Request records from:

☐ Request copy of police report.

Doctor notes: _____

_____

_____

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Symptoms

Please fill in all symptoms you currently have *that you did not have* before the accident.

Orthopedic & Musculoskeletal Symptoms

- ☐ "Clunk" Sound with Neck Movements
- ☐ Neck Pain
- ☐ Upper Back Pain
- ☐ Low Back Pain
- ☐ Shoulder Pain . . . . . ☐ Left ☐ Right
- ☐ Upper Arm Pain . . . . . ☐ Left ☐ Right
- ☐ Elbow Pain . . . . . ☐ Left ☐ Right
- ☐ Forearm Pain . . . . . ☐ Left ☐ Right
- ☐ Wrist Pain . . . . . ☐ Left ☐ Right
- ☐ Hand Pain . . . . . ☐ Left ☐ Right
- ☐ Hip Pain . . . . . ☐ Left ☐ Right
- ☐ Upper Leg Pain . . . . . ☐ Left ☐ Right
- ☐ Knee Pain . . . . . ☐ Left ☐ Right
- ☐ Lower Leg Pain . . . . . ☐ Left ☐ Right
- ☐ Ankle Pain . . . . . ☐ Left ☐ Right
- ☐ Foot Pain . . . . . ☐ Left ☐ Right
- ☐ Jaw Pain
- ☐ Clicking in Jaw
- ☐ Pain when Chewing
- ☐ Face Pain
- ☐ Chest Pain
- ☐ Stomach Pain
- ☐ Bruise/Contusion to Abrasion/Scrape
- ☐ to Other
- ☐ Symptom Other Symptom _____
- ☐

Neurological Symptoms

- ☐ Numb/Tingling Arm/Hand L R
- ☐ Numb/Tingling Leg/Foot L R
- ☐ Weakness Arm/Hand L R
- ☐ Numb/Tingling Arm/Hand L R

Symptoms Associated with Injuries

- ☐ Range of Motion Problems
- ☐ Headaches
- ☐ Muscle Spasms
- ☐ Dizziness
- Visual Disturbances
- ☐ Sleep Disruption
- ☐ Radiating Pain "travels down arms / legs"
- ☐ Anxiety
- ☐ Depression
- ☐ I am taking over-the-counter pain meds

Brain/Neuropsych/MTBI Symptoms

- ☐ Wanting to Be Alone
- ☐ Sleepiness
- ☐ Nausea/Vomiting
- ☐ Difficulty Concentrating
- ☐ Day Dreaming/Staring/Mindless Staring
- ☐ Mood Swings
- ☐ Agitation
- ☐ Sadness or Tearful
- ☐ Blurry Vision
- ☐ Double Visions
- ☐ Disoriented
- ☐ Confused
- ☐ Difficulty Speaking
- ☐ Feelings of Isolation from Others
- ☐ Attention Problems
- ☐ Appetite Change
- ☐ Pupils Different Sizes
- ☐ Room Spins/Woozy Feeling
- ☐ Balance Problems
- ☐ Difficulty Walking
- ☐ Difficulty Focusing/Easily Distracted
- ☐ Very Tired
- ☐ Dozing During the Day
- ☐ Personality Change
- ☐ Can't Remember Numbers
- ☐ Reading Problems
- ☐ Writing Problems
- ☐ Difficulty with Adding/Subtracting
- ☐ Poor Attention
- ☐ Difficulty Learning New Things
- ☐ Difficulty Understanding
- ☐ Difficulty Remembering Things
- ☐ Re-reading Things to Understand Them
- ☐ Anger
- ☐ Difficulty Making Decisions
- ☐ Change in Sexual Functioning
- ☐ Reduced Conftdence
- ☐ Apathy (Don't Care)
- ☐ Irritable
- ☐ Change in Sense of Taste or Smell
- ☐ Flashbacks to Accident
- ☐ Impatience
- ☐ Frustration
- ☐ Hearing Problems
- ☐ Difficulty Planning or Organizing

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Signature: _____ Date: / /

The Neck Disability Index

Please read instructions:
This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1-PAIN INTENSITY

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2-PERSONAL CARE (Washing, Dressing, etc.)

- ☐ I can look after myself normally, without causing extra pain.
- ☐ I can look after myself normally, but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help, but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3-LIFTING

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4-READING

- ☐ I can read as much as I want to, with no pain in my neck.
- ☐ I can read as much as I want to, with slight pain in my neck.
- ☐ I can read as much as I want to, with moderate pain in my neck.
- ☐ I can't read as much as I want, because of moderate pain in my neck.
- ☐ I can hardly read at all, because of severe pain in my neck.
- ☐ I cannot read at all.

SECTION 5-HEADACHES

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 6-CONCENTRATION

- ☐ I can concentrate fully when I want to, with no difficulty.
- ☐ I can concentrate fully when I want to, with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

SECTION 7-WORK

- ☐ I can do as much work as I want to.
- ☐ I can do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

SECTION 8-DRIVING

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want, with slight pain in my neck.
- ☐ I can drive my car as long as I want, with moderate pain in my neck.
- ☐ I can't drive my car as long as I want, because of moderate pain in my neck.
- ☐ I can hardly drive at all, because of severe pain in my neck.
- ☐ I can't drive my car at all.

SECTION 9-SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10-RECREATION

- ☐ I am able to engage in all my recreation activities, with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some neck pain at all.
- ☐ I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
- ☐ I am able to engage in few of my recreation activities, because of pain in my neck.
- ☐ I can hardly do any recreation activities, because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Instructions:

1. The NDI is scored in the same way as the Oswestry Disability Index.

2. Using this system, a score of 10-28% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.

Oswestry Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | ***Unbearable pain***

Name _____ **Date** _____

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 – Pain Intensity
0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)
0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 – Walking
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 – Sitting
0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 – Standing
0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7 – Sleeping
0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social Life
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Section 9 – Traveling
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

TOTAL _____

Consent for Purposes of Treatment, Payment and Healthcare Operations

In this document, “I” and “my” refer to the patient, and “Chiropractor” refers to Clifford J. Fisher or Rick F.J. Swecker or Jack Nolle or Steve Perry or Rachel Robison.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.

I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have a right to be provided with a copy of the Notice of Privacy Practices of Chiropractors and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is available at 2155 Green Vista Drive Suite 202, Sparks, NV 89431 and at 9476 Double R Boulevard Suite A, Reno, NV 89521 and at our website at FFCwecare.com. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment. A revised copy will also be available on our web site at RenoSparksChiro.com.

Signature of Patient or Personal Representative	Printed Name of Patient
Date of Signing	Witness

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Insurance Information

Policy Holder Name: _____

Patient Name: _____ Date Today: _____

Employer: _____ Insurance ID #: _____

Health Insurance Co. _____ Policy# _____

Address _____

City, State, Zip _____

Adjuster _____ Phone _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Family First Chiropractic extends credit to me and I also 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 unless prior arrangements are made. I hereby authorize the doctors at Family First Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment, I certify that the following information is true and correct.

I hereby instruct and direct _____ Insurance Company to pay by check issued to and mailed to:

- ☐ Family First Chiropractic, 2155 Green Vista Dr. #202, Sparks NV 89431
- ☐ Family First Chiropractic, 9476 Double R Blvd. Suite A, Reno, NV 89521

or if my current policy prohibits direct payment to doctor, I hereby also instruct and direct my insurance company to issue the check to me and mail it to the address as follows:

- ☐ Family First Chiropractic, 2155 Green Vista Dr. #202, Sparks NV 89431
- ☐ Family First Chiropractic, 9476 Double R Blvd. Suite A, Reno, NV 89521

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

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.

_____ _____

Date Witness

_____ _____

Signature of Policyholder Signature of Claimant, if other that Policyholder

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