NEW PATIENT INTAKE

Chiropractic [personal injury]

Account #: _____

Thank you for choosing Bountiful Life Chiropractic Center. We are committed to providing you and your family the highest quality of chiropractic care so you may enjoy an active and healthy lifestyle. Prior to your consultation, please complete the following paperwork as thoroughly as possible in order for us to gain a clear understanding of your health goals.
*We will require a photocopy of your **driver's license** (or government identification) for our records.*
We comply with all federal privacy standards. As such, all information you provide is confidential.

Date of the Accident: _____

Legal Name: _____

Date of Birth: _____ Age: _____ Nickname / Name you go by: _____

Caretaker's Name (if applicable): _____

Gender: ☐ Male ☐ Female

Primary Phone #: (_____)_____-_____ ☐ Cell ☐ Home

Secondary Phone #: (_____)_____-_____ ☐ Cell ☐ Home

*By providing us with a cell number, you will automatically be enrolled in **text appointment reminders**.*

Email: _____

Email appointment reminders *in addition* to text reminders? ☐ Yes ☐ No

Preferred method(s) of communication: ☐ Phone Call ☐ Text ☐ Email

Address: _____ City, State: _____ Zip: _____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed

Spouse/Partner's Name (if applicable): _____ Phone #: (_____)_____-_____

Emergency Contact Name (if other than spouse): _____ Phone #: (_____)_____-_____

Do you have children? ☐ Yes ☐ No If yes, how many? _____

How did you hear about our clinic? (check all that apply)

☐ Google Search ☐ Facebook ☐ Instagram ☐ Referral from: (name) _____
(We will thank them with a special gift!)

☐ Driving by ☐ Other (please describe): _____

SYMPTOM SURVEY

Please mark each applicable symptom with a 1 or 2

1 – Currently experiencing (in the last 6-8 weeks) | 2 – Have experienced in the past

GENERAL

___ Chills
___ Convulsions
___ Dizziness/loss of balance
___ Fainting
___ Fever
___ Headaches/migraines
___ Insomnia
___ Weight loss/gain
___ Nerve pain
___ Nervousness/anxiety
___ Depression
___ Numbness
___ Sweats
___ Tremors
___ Cancer
___ Diabetes - type 1 or type 2?
___ Stroke
___ Seizures

EYES

___ Corrective lenses or contacts
___ Far sighted
___ Near sighted
___ Cataracts
___ Blind spots
___ Sensitivity to light
___ Eye pain

EARS, NOSE, & THROAT

___ Allergies
___ Colds
___ Deafness
___ Hearing loss
___ Ear aches
___ Ear discharge
___ Ear ringing (tinnitus)
___ Enlarged glands
___ Enlarged thyroid
___ Dental decay
___ Gum trouble
___ Loss of taste
___ Hoarseness
___ Nose bleeds
___ Sore throats
___ Sinus infections
___ Nasal obstruction
___ Loss of smell

MUSCULOSKELETAL

___ Arthritis
___ Bursitis
___ Hernia
___ Low back pain
___ Mid back pain
___ Neck pain/stiffness
___ Arm pain
___ Shoulder pain
___ Leg pain
___ Knee pain
___ Foot pain
___ Muscle cramps
___ Fractures
___ Sciatica
___ Spinal curvature

GENITO-URINARY

___ Bed wetting
___ Blood in urine
___ Frequent urination
___ Inability to control bladder
___ Kidney infection
___ Kidney stones
___ Painful urination
___ Pus in urine

CARDIOVASCULAR

___ High blood pressure
___ Low blood pressure
___ Heart disease
___ Pain over heart
___ Rapid heart rate
___ Slow heart rate
___ Poor circulation
___ Cold extremities (hands/feet)
___ Bruise easily
___ Swelling of ankles
___ Pacemaker
___ Varicose veins

RESPIRATORY

___ Asthma
___ Bronchitis
___ Chest pain
___ Chronic cough
___ Difficulty breathing
___ Spitting up blood
___ Spitting up phlegm
___ Wheezing

GASTROINTESTINAL

___ Belching or gas
___ Abdominal pain
___ Constipation
___ Diarrhea
___ Difficult digestion
___ Poor appetite
___ Ulcers
___ Vomiting
___ Vomiting blood
___ Abdominal bloating
___ Excessive hunger
___ Heartburn/reflux
___ Hemorrhoids
___ Jaundice/liver issues
___ Nausea
___ Gallbladder issues
___ Colitis
___ Irritable bowel syndrome

WOMEN ONLY

___ Pregnant (currently)
___ Possibly pregnant
___ Painful menstruation
___ Menstrual cramps
___ Hot flashes
___ Irregular cycle
___ PCOS
___ Lumps in breast(s)
___ Vaginal discharge
___ Nipple discharge
___ Pregnancy complications
___ Miscarriage
___ Infertility

MEN ONLY

___ Prostate problems
___ Erectile dysfunction
___ Hesitancy/dribbling
___ Infertility

Please mark all that apply.

DO YOU HAVE LACERATIONS, CUTS OR BRUISING?

___ Head or Face
___ Neck
___ Seat belt bruising
___ Cuts or bruising on your chest
___ Cuts or bruising on arms
___ Cuts or bruising on legs
___ Other: _____

HEAD INJURIES: (now or at the time of the accident)

___ Knocked-out or unconscious
___ Headaches
___ Face pain
___ Pupils different sizes
___ Dizziness
___ Difficulty walking
___ Balance problems
___ Room spins
___ Disoriented confusion
___ Day dreaming
___ Attention problems
___ Hearing problems
___ Change in sense of smell or taste
___ Difficulty speaking
___ Memory problems
___ Very tired or fatigued
___ Appetite change
___ Sleep difficulties
___ Visual disturbances, blurry or double vision
___ Flashbacks to accident
___ Problems to read or write
___ Problems adding or subtracting
___ Problems learning new things
___ Problems understanding
___ Problems remembering numbers
___ Difficulty concentrating
___ Difficulty remembering things
___ Difficulty making decisions
___ Change in sexual functioning
___ Nausea/Vomiting
___ Change of personality
___ Wanting to be alone
___ Mood swings
___ Sadness
___ Agitation
___ Anger
___ Helplessness
___ Reduce confidence
___ Apathy
___ Irritability
___ Sleepiness
___ Frustration
___ Impatience
___ Other: _____

JAW PROBLEMS:

___ Jaw pain
___ Clicking
___ Pain while chewing
___ Pain while talking
___ Pain while yawning
___ Pain while moving jaw from side-to-side

NECK INJURIES:

___ Neck pain
___ Neck pain, numbness, tingling, weakness that radiates or goes down to RIGHT shoulder, arm, forearm or hand
___ Neck pain, numbness, tingling, weakness that radiates or goes down to LEFT shoulder, arm, forearm or hand
___ Neck pain, numbness, tingling, weakness that radiates or goes down to RIGHT UPPER BACK
___ Neck pain, numbness, tingling, weakness that radiates or goes down to LEFT UPPER BACK
___ Neck pain that causes headaches
___ Neck spasms or shoulder spasms
___ Popping, clicking, or clunking sound with neck movement

SHOULDER INJURIES

___ Shoulder pain LEFT RIGHT BOTH
___ Shoulder pain with movement
LEFT RIGHT BOTH
___ Shoulder spasms LEFT RIGHT BOTH
___ Sharp shoulder pain
___ Dull shoulder pain
___ Achy shoulder pain
___ Pins and needles shoulder pain
___ Shoulder pain that radiates/shoots pain into arm
___ Other: _____

UPPER ARM PAIN: RIGHT LEFT BOTH

___ Dull
___ Ache
___ Sharp
___ Stabbing
___ Other: _____

ELBOW PAIN: RIGHT LEFT BOTH

___ Dull
___ Ache
___ Sharp
___ Stabbing
___ Other: _____

FOREARM: RIGHT LEFT BOTH

___ Dull
___ Ache
___ Sharp
___ Stabbing
___ Other: _____

WRIST PAIN: RIGHT LEFT BOTH

___ Dull
___ Ache
___ Sharp
___ Stabbing
___ Other: _____

HAND PAIN: RIGHT LEFT BOTH

___ Dull
___ Ache
___ Sharp
___ Stabbing
___ Other: _____

MID BACK PAIN OR UPPER BACK PAIN

___ Upper or mid back pain
___ Upper back pain, numbness, tingling, weakness that radiates or goes down to RIGHT shoulder, arm, forearm or hand
___ Upper back pain, numbness, tingling, weakness that radiates or goes down to LEFT shoulder, arm, forearm or hand
___ Upper or mid back spasms

LOW BACK PAIN:

___ Low back pain
___ Low back pain, numbness, tingling, weakness that radiates or goes down to RIGHT buttock, thigh, leg or foot
___ Low back pain, numbness, tingling, weakness that radiates or goes down to LEFT buttock, thigh, leg or foot
___ Low back spasms

PELVIC OR SACRAL PAIN

___ Pelvic pain, numbness, tingling, weakness that radiates or goes down to RIGHT buttock, thigh, leg or foot
___ Pelvic pain, numbness, tingling, weakness that radiates or goes down to LEFT buttock, thigh, leg or foot
___ Sacral pain (tail bone)
___ Coccygeal or coccyx (tail bone) pain

HIP PAIN:

___ Left hip pain
___ Left hip pain, numbness, tingling, weakness that radiates or goes down to LEFT buttock, thigh, leg or foot
___ Right hip pain
___ Right hip pain, numbness, tingling, weakness that radiates or goes down to RIGHT buttock, thigh, leg or foot

UPPER LEG PAIN: RIGHT LEFT BOTH

___ Upper leg pain that radiates to knee
___ Upper leg spasms

KNEE PAIN: RIGHT LEFT BOTH

___ Knee pain that radiates to calf
___ Knee pain that radiates to calf and ankle
___ Knee pain that radiates to calf, ankle and foot

ANKLE PAIN: RIGHT LEFT BOTH

___ Ankle pain that radiates to foot
___ Ankle and foot pain

FOOT PAIN: RIGHT LEFT BOTH

___ Dull
___ Ache
___ Sharp
___ Stabbing
___ Other: _____

CHEST PAIN

___ Dull
___ Ache
___ Sharp
___ Stabbing
___ Other: _____

STOMACH PAIN

___ Dull
___ Ache
___ Sharp
___ Stabbing
___ Other: _____

OTHER SYMPTOMS:

_____
_____
_____

ACCIDENT QUESTIONNAIRE

DATE OF ACCIDENT: _____

VEHICLE TYPE :

___ Sports Car
___ Coupe
___ Sedan
___ Sport Utility Vehicle (SUV)
___ Station Wagon
___ Pick-up truck
___ Bus
___ Other: _____
Year: _____
Make: _____
Model: _____
Estimated Speed: _____mph

VEHICLE SIZE:

___ Compact
___ Mid-Sized
___ Full-Sized

ACTIONS OF YOUR VEHICLE:

___ crossing an intersection
___ stopped at an intersection
___ stopped for a pedestrian
___ stopped for traffic
___ traveling at posted speed limit
___ traveling faster than the posted speed limit
___ turning

HOW WAS YOUR VEHICLE HIT:

___ hit head-on
___ hit on the left front
___ hit on the right front
___ hit on the left rear
___ hit on the right rear
___ rear-ended
___ Other: _____

DAMAGE TO YOUR VEHICLE:

___ complete
___ extensive
___ minimal
___ moderate

DESCRIBE THE <u>SECOND</u> VEHICLE:

___ Compact
___ Mid-Sized
___ Full-Sized
___ Semi-Trailer
___ Other: _____
Year: _____ Make: _____
Model: _____
Estimated Speed: _____mph

DAMAGE TO THE OTHER VEHICLE?

___ complete
___ extensive
___ minimal
___ moderate

WEATHER CONDITIONS:

___ Clear
___ Cloudy
___ Drizzling
___ Foggy
___ Rainy
___ Snowy
___ Stormy
___ Sunny

ROAD CONDITIONS:

___ Damp
___ Dry
___ Dry with icy patches
___ Iced over
___ Snowed over
___ Wet

<u>DESCRIBE THE MOMENT OF IMPACT</u>

BODY POSITION AT TIME OF IMPACT:

___ leaning forward
___ slouched down in seat
___ straight
___ turned to the left
___ turned to the right

DIRECTION BODY WAS THROWN:

___ backward then forward
___ forward then backward
___ to the left
___ to the right
___ about the vehicle
___ outside the vehicle
___ under the vehicle

HEAD POSITION AT IMPACT:

___ straight
___ tilted forward
___ turned to the left
___ turned to the right

DIRECTION HEAD WAS THROWN:

___ backward then forward
___ forward then backward
___ side to side

TYPE OF RESTRAINT:

___ lap belt
___ shoulder belt
___ shoulder lap belt

WHERE WERE YOU WAS SEATED IN THE VEHICLE:

___ driver
___ front passenger
___ back passenger driver side
___ back passenger right side
___ back passenger middle
___ Other: _____

DID AIRBAGS DEPLOY:

___ Yes
___ No

WERE YOU SEEN AT A MEDICAL FACILITY FOLLOWING YOUR ACCIDENT?

___ Yes
___ No

If so, name and address of the facility:

_____

_____

DUTIES PERFORMED UNDER DURESS AT WORK AND HOME

PLEASE CHECK ALL THAT APPLY TO YOUR WORK *BECAUSE OF THE ACCIDENT*:

___ I go to work but work in pain
___ I limit my work activities
___ Bending at work hurts
___ Stooping at work hurts
___ Sitting at work hurts
___ Using the computer at work hurts
___ Pushing at work hurts
___ Kneeling at work hurts
___ I have lost status in my company
___ I have lost job security
___ I didn't get a promotion
___ I don't enjoy work as much as before
___ I doze off at work
___ I take unpaid time off work to go to Dr.
___ I daydream at work more than before
___ I feel tired at work
___ I work in pain because I have bills to pay
___ I can't take time off because I would lose my job
___ I keep working so I don't lose status at company
___ My business would fail if I took time off
___ I believe in working even when I'm in pain
___ I feel obligated to work even though I'm in pain
___ My business would lose money if I took time off
___ My work is not as good as it was before accident
___ My boss reprimanded me for poor performance
___ I got a different job within the same company
___ I got a different job in another company
___ I make less money than before the accident
___ I cannot do the same work/job as before accident
___ I can't concentrate as well at work
___ I take paid time off to go to Dr.
___ I make mistakes at work I didn't use to
___ I hide my poor work performance from my boss

PLEASE CHECK ALL THAT APPLY TO YOUR HOME/DOMESTIC LIFE *BECAUSE OF THE ACCIDENT*:

___ My house is not as clean now
___ My yard is not as neat now
___ My garden is not as productive now
___ I do yard work, but do it in pain
___ I cannot do my normal yard work
___ I do house work, but do it in pain
___ I cannot do my normal house work
___ Doing laundry hurts me
___ I cannot do laundry now
___ Washing dishes hurts me
___ I cannot vacuum now
___ Cooking hurts me
___ I cannot cook now
___ Washing the car hurts me
___ I cannot wash my car
___ I cannot take time off because I care for children
___ I have _____children ages_____
___ I had to hire a paid housekeeper
___ I asked someone for unpaid housekeeping help
___ I had to hire a paid gardener
___ I asked someone for unpaid yard work help
___ Mowing the lawn hurts me
___ I cannot mow the lawn
___ Taking out the trash hurts me
___ I cannot take out the trash
___ I do not enjoy my gardening/yardwork like I used to
___ I do not enjoy my housework like I used to
___ Gardening hurts me
___ I cannot do my gardening at all since the accident
___ Others living with me do my share of the work now
___ Others living with me do my share of the yard now
___ Others living with me do my share of the gardening

Have you seen a chiropractor before? ☐ Yes ☐ No If yes, when? _____

Surgeries (with approx. dates): _____

_____

_____

Illnesses (with approx. dates): _____

_____

Accidents, Falls, Traumas (with approx. dates): _____

_____

Have you had a concussion? ☐ Never ☐ One time ☐ Multiple times ☐ I think so, but not sure

Do you smoke or use other tobacco products? ☐ Never ☐ Occasionally ☐ Regularly ☐ I've quit

Do you drink alcohol? ☐ Never ☐ Occasionally ☐ Regularly ☐ I've quit

Do you drink caffeinated beverages? ☐ Never ☐ Occasionally ☐ Regularly ☐ I've quit

Please list current medications: _____

_____

Please list current vitamins or supplements: _____

_____

Are you allergic to any medications? ☐ Yes ☐ No If yes, which ones? _____

Are you allergic to any foods? ☐ Yes ☐ No If yes, which ones? _____

_____

What condition(s) led you to seek chiropractic care? _____

_____

_____

When did you first notice it? _____

What were you doing when you first noticed it? _____

_____

Have you had this condition / these symptoms before? ☐ Yes ☐ No If yes, when? _____

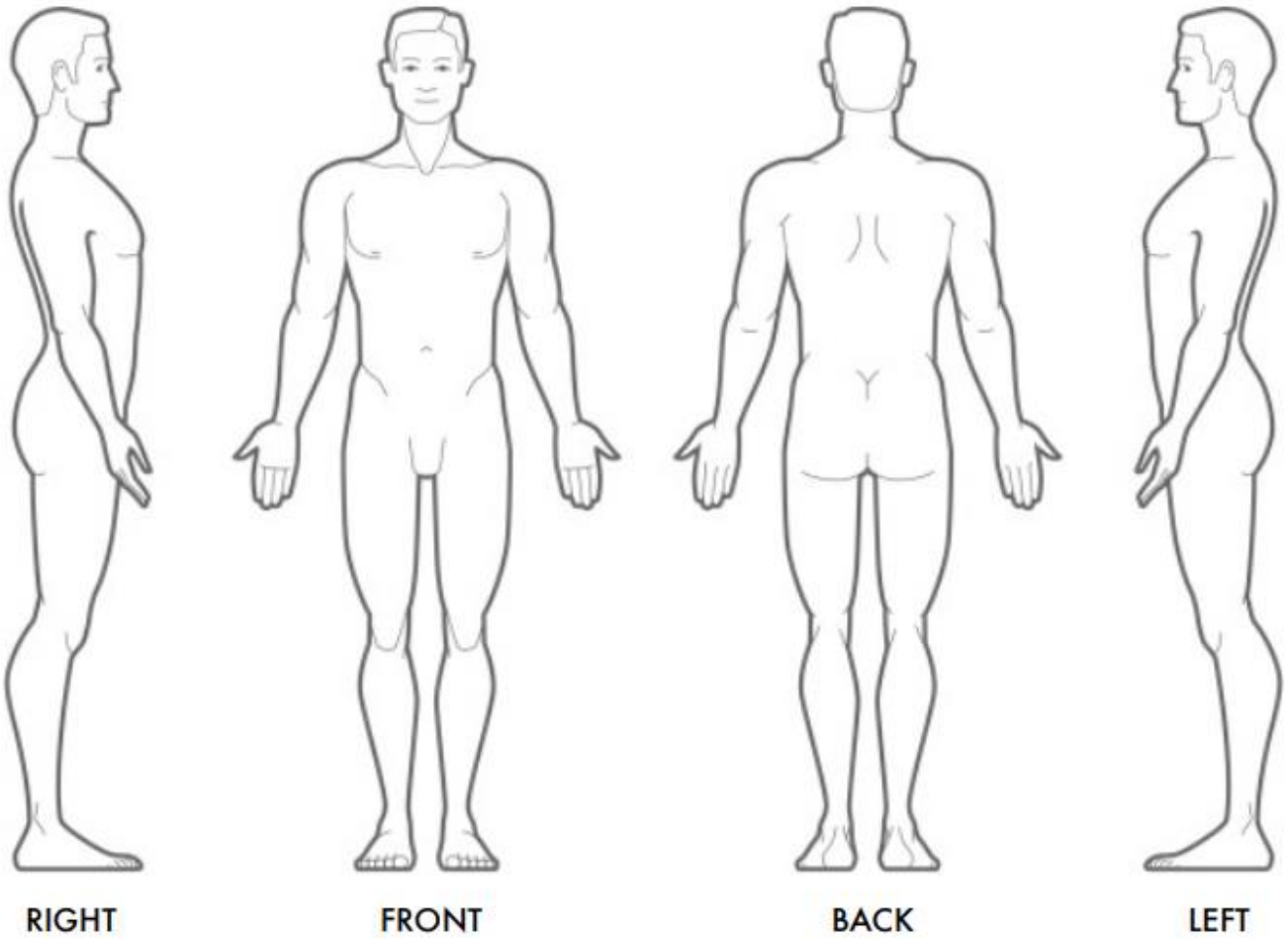
Do the symptoms radiate or travel to another area? ☐ Yes ☐ No ☐ Not sure

If yes, please describe: _____

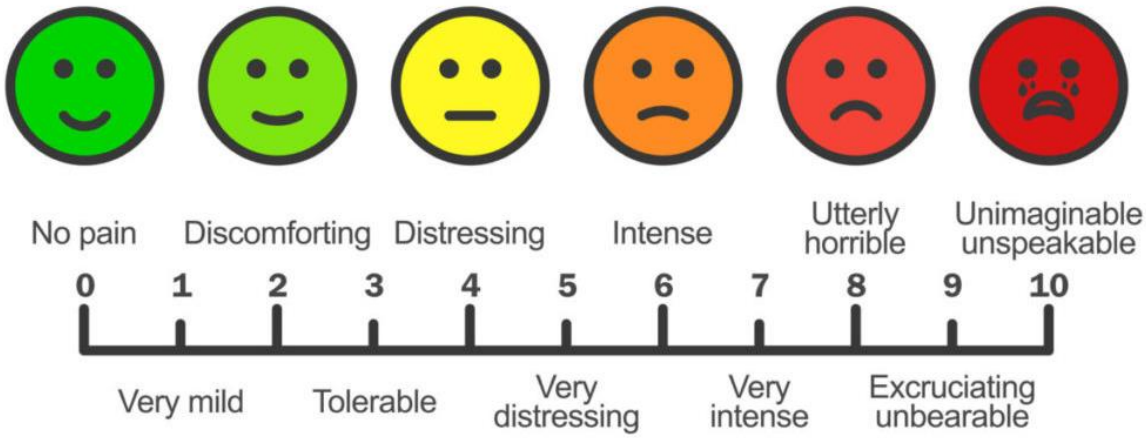
How frequently do you experience symptoms? (circle one)

Intermittently	Occasionally	Frequently	Constantly
[0-25% of day]	[26-50% of day]	[51-75% of day]	[76-100% of day]

Place an "X" on the diagram below in the locations you are experiencing symptoms:



How would you rate the intensity of your pain? (circle a number)



Is the pain (circle all that apply): Sharp Dull Aching Burning Numb Throbbing Pins & Needles

What makes your symptoms better? _____

What makes your symptoms worse? _____

What movements/activities are difficult with your condition? _____

_____

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

I authorize Bountiful Life Chiropractic Center to release my personal health care information to any third party pertaining to this personal injury case. This authorization will remain in effect unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

Signature: _____Date:_____

(Signature of Patient or Legal Guardian if under age 18)

PERSONAL INJURY / CAR ACCIDENT PAYMENT OPTIONS

Thank you for entrusting us with your chiropractic care! We know that injuries/accidents are often stressful both emotionally and physically, and we are here to assist you with the entire process as we are able.

There are two options to cover chiropractic care:

1. Use the Medical Pay Option from YOUR car insurance.
2. Pay Cash/Check/Credit Card at time of service.

File a claim with your personal insurance policy, utilizing your MedPay Coverage. Our clinic will direct bill your insurance company on a bi-weekly basis providing them with the necessary appointment information. No payment from you is due at time of service. You will be financially responsible at time of purchase for any supplements and/or products. **Once your MedPay benefit reaches its policy limit, you will be responsible for payment at the time service. It is your responsibility to know the policy insurance coverage limits. In the event that certain charges are rejected by the insurance company it would then become your responsibility to ensure that payment for those charges is received.*

Pay Cash/Check/Credit Card at time of service. This option is available if you do not file a claim against your car insurance MedPay benefits. In this instance we will provide all of the billing and appointment information and send to the designated third-party insurance or legal representative. You may be eligible for reimbursement from your insurance company for chiropractic services you paid for at the time of service.

If filing a claim with your insurance MedPay benefit, please provide the following information:

Your MedPay Limit: $_____ Med Pay Claim #: _____

Your Vehicle Insurance Name: _____

Address listed on your card: _____

Phone # listed on your card: _____

Med Pay Rep Name: _____

Rep's Phone #: _____Rep's Fax #: _____

Third-party insurance contact or legal representative (if applicable):_____

Third-party claim number: _____

Third-party contact's phone number: _____

Third-party contact's email: _____

TERMS OF ACCEPTANCE

Chiropractic has only one goal - to serve the health needs of you, the patient. When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral or extremity subluxation. Our chiropractic method of correction is by specific adjustments of the spine, as well as extremities.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Extremity Subluxation: A misalignment of an extremity causing edema, fixation and or joint irregularity. The aim of extremity adjusting is to assess the extremity, then do an analysis, and then develop a treatment for the extremity and synchronize this plan with the plan for the spinal treatment.

We may diagnose any condition or disease that comes into our office in addition to the vertebral and extremity subluxations. It is our goal to refer a patient to their health care practitioner, or in urgent matters, to the closest emergency room if we feel their health, or our diagnosis, warrants the referral.

We do not treat diseases or conditions in our office beyond the spine or extremities; however, other diseases may improve with chiropractic care. In doing so, it's important to work with you, the patient, on reaching your optimal health. Our only practice objective is to serve you, the patient.

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or 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 affect 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 this office 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.

If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

X-RAY RELEASE

This is to certify that Dr. LaBounty & Dr. Miller have my permission to perform an X-ray evaluation.

To the best of my knowledge, I am not pregnant, and I understand that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

PAYMENT / INSURANCE

I understand that Bountiful Life Chiropractic Center will provide a receipt to assist me in making collection from any insurance company. I clearly understand that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I have read and understand the above, and I agree to these policies and procedures. All questions about this page have been answered to my satisfaction, and I therefore accept care at Bountiful Life Chiropractic Center on this basis.

Patient Signature: _____

Printed Name: _____ Date: _____