First Choice Family chiropractic Rehab & Massage

Patient Information

Today's Date: _____ Birth Date: _____ SS#: _____
First Name: _____ M. I.: _____ Last Name: _____
Address: _____ City: _____ State: _____
Zip: _____ Sex: □ M □ F Age: _____ Email: _____
Cell: (___)_____ Home: (___)_____

Preferred Reminder Type(Please circle): Phone Call Email Text Message
Cell Carrier:_____
Emergency Contact: _____ Relationship: _____
Cell: (___)_____ Home: (___)_____ Work: (___)_____
□ Married □ Single □ Minor □ Widowed □ Divorced
Patient Employer/School: _____ Occupation: _____
Employer/School Address: _____ Phone Number: _____
How did you hear about us? _____

Accident Information

Is condition due to an accident? □ Yes □ No Date_____ Type of accident: □Work □Auto □Home □Other
To whom have you made a report of your accident? □Auto Insurance □Employer □Work Comp. □Other
Attorney Name (if applicable): _____

Patient Condition

Reason for Visit: _____

When did your symptoms appear? _____

How often do you have this condition?
□Constant □ Occasional □ Rarely

What activities worsen your pain?
□ Bending □ Sleeping □ Lifting □ Coughing □ Standing □ Arising From a Chair □ Exercising □ Other

What activities relieve your pain?
□ Pain Meds □ Stretching □ Sitting □ Walking □ Standing □ Heat/Cold □ Exercising □ Other

Surgical History:
Type: _____ **Where** _____ **When** _____
Type: _____ **Where** _____ **When** _____
Type: _____ **Where** _____ **When** _____

Hospitalizations:
Cause _____ **When** _____ **Remaining Problems** _____
Cause _____ **When** _____ **Remaining Problems** _____
Cause _____ **When** _____ **Remaining Problems** _____

Broken Bones: _____ **When** _____ **Surgeries** _____
_____ **When** _____ **Surgeries** _____
_____ **When** _____ **Surgeries** _____

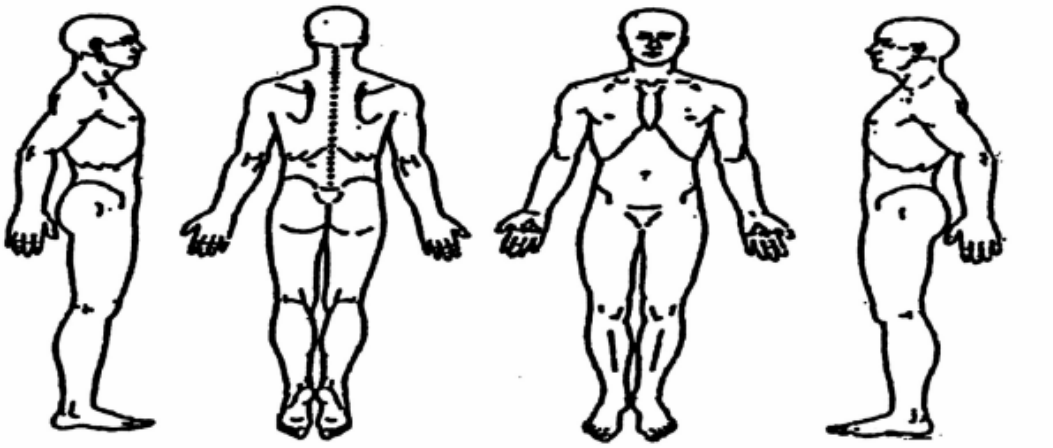
Previous tests for THIS condition:
□ **X Ray** **Date:** _____ **Ordered By:** _____
□ **MRI** **Date:** _____ **Ordered By:** _____
□ **Other** **Date:** _____ **Ordered By:** _____

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation □ Other

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What aggravates your problem?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ Weight _____ Date of Birth _____
Occupation _____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

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	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:_____				

20. List all prescription medications you are currently taking:
_____

21. List all of the over-the-counter medications you are currently taking:
_____

22. List all surgical procedures you have had:
_____

23. What activities do you do at work?
□ **Sit:** □ Most of the day □ Half the day □ A little of the day
□ **Stand:** □ Most of the day □ Half the day □ A little of the day
□ **Computer work:** □ Most of the day □ Half the day □ A little of the day
□ **On the phone:** □ Most of the day □ Half of the day □ A little of the day

24. What activities do you do outside of work?
_____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date:**_____

First Choice Family chiropractic Rehab & Massage

Personal Injury Questionnaire

1. What was the date of the accident? _____
2. What type of impact was the auto accident? _____
3. Did you vehicle hit anything after the accident? □ Yes □ No If yes, describe: _____
4. Where were you sitting in the vehicle during the accident? _____
5. Did you know the accident was coming? □ Yes □ No
6. What type of vehicle were you in? _____
7. What type of vehicle impacted yours? _____
8. At the time of the impact, how fast was your vehicle moving? _____
9. During and after the crash what happened to your vehicle? (check all that apply)
   - □ Kept going straight
   - □ Kept going straight hitting a car in front
   - □ Was hit by another vehicle
   - □ Spun around
   - □ Spun around and hit a stationary object
   - □ Hit a stationary object
10. Did you lose consciousness during the accident? □ Yes □ No
    a. If yes, How long? _____
11. How was your head positioned during the accident? _____
12. How was your torso positioned during the accident? _____
13. How were your hands positioned during the accident? _____
14. Did your head hit anything during the accident? □ Yes □ No
    If yes, describe: _____
15. Did your face hit anything during the accident? □ Yes □ No
    If yes, describe: _____
16. Did your shoulders hit anything during the accident? □ Yes □ No
    If yes, describe: _____
17. Did your neck hit anything during the accident? □ Yes □ No
    If yes, describe: _____
18. Did your chest hit anything during the accident? □ Yes □ No
    If yes, describe: _____

19. Did your hips hit anything during the accident? □ Yes □ No
    If yes, describe: _____

20. Did your knees hit anything during the accident? □ Yes □ No
    If yes, describe: _____

21. Did your feet hit anything during the accident? □ Yes □ No
    If yes, describe: _____

22. What kind of headrest was in your vehicle?
    - movable fixed headrest - nonmovable fixed headrest - no headrest

23. Where was the headrest positioned on your head? _____

24. Did you have your seatbelt on during the accident? □ Yes □ No

25. Did you slide out of your seatbelt during the accident? □ Yes □ No

26. What was damaged in your vehicle? Check all that apply

- □ Windshield
- □ Steering wheel
- □ Dashboard
- □ Seat frame
- □ Side window
- □ Rear window
- □ Rear bumper
- □ Front bumper
- □ Trunk
- □ Front left door
- □ Front right door
- □ Back left door
- □ Back right door
- □ Mirror
- □ Knee bolster
- □ Back right door
- □ **Completely totaled**

27. Circle the items that dented inward
    Floorboards Side Door Dashboard

28. Circle the doors that would not open as a result of the accident
    Front Left Front Right Back Left Back Right

First Choice Family chiropractic Rehab & Massage

Post Injury Assessment

Immediately following the accident I felt:

- □ Dizzy/Dazed
- □ Disorientated
- □ Unconscious
- □ Nervous
- □ Nauseous
- □ Upset
- □ Weak
- □ Other _____

Where did you have the pain? Check all that apply.

- □ Head
- □ Neck
- □ Right Shoulder
- □ Left Shoulder
- □ Right arm
- □ Left arm
- □ Right forearm
- □ Left forearm
- □ Right Hand
- □ Left Hand
- □ Low Back
- □ Left buttock
- □ Right buttock
- □ Left thigh
- □ Right thigh
- □ Left knee
- □ Right knee
- □ Left foot
- □ Right foot
- □ Left hip
- □ Right hip
- □ Other _____

Did you receive any cuts? If yes, where?

- □ **Yes**
- □ **No**

If yes, describe:

_____
_____
_____
_____

What was your immediate destination after the accident? _____

How did you get there? _____

Were you admitted to a hospital? □ Yes □ No

Date of initial visit if yes: _____ Date of Discharge: _____

Name of Hospital: _____
Attending Physician: _____
Diagnosis of Injury: _____
_____

How did you get to the hospital?

- □ Ambulance
- □ Police Car
- □ Private Transportation
- □ Other: _____

Treatment Given at Hospital?

- □ None
- □ Adjustments
- □ Placed in cervical collar
- □ X-Rayed
- □ Stitches
- □ Given Pain Medication
- □ Surgery
- □ Other: _____

Medications Prescribed

- □ Antibiotic
- □ Anti-inflammatory
- □ Anxiety
- □ Muscle Relaxant
- □ Pain
- □ Other: _____
  _____

Any additional comments? _____
_____
_____

Duties Under Duress

Check all the words that best describe your symptoms

- □ Throbbing
- □ Shooting
- □ Sharp
- □ Burning
- □ Aching
- □ Numbing
- □ Cramping
- □ Dull
- □ Constant
- □ Intermittent (comes and goes)

Work Restrictions

- □ None/Does not apply
- □ Lifting/Bending
- □ Driving
- □ Standing
- □ Sitting
- □ Other: _____
    - o I was not having difficulty with work tasks prior to this injury
    - o My current injuries are the reason I am having difficulties with work tasks.

School Restrictions

- □ None/Does not apply
- □ Sitting
- □ Paying attention
- □ Socializing with friends
- □ Other: _____
    - o I was not having difficulty with school tasks prior to this injury
    - o My current injuries are the reason I am having difficulties with school tasks.

Hobbies

- □ None/Does not apply
- □ Sports – Specify: _____
- □ Dancing
- □ Exercising – Specify: _____
- □ Entertainment – Specify: _____
- □ Other: _____
    - o I was not having difficulty with these hobbies prior to this injury
    - o My current injuries are the reason I am having difficulties with these hobbies.

Household Duties

- □ None/Does not apply
- □ Vacuuming
- □ Caring for Children
- □ Dishes/Dusting/Laundry
- □ Meal Preparation
- □ Yard Work
- □ Taking out Trash
- □ Driving
- □ Other: _____
    - o I was not having difficulty with these household tasks prior to this injury
    - o My current injuries are the reason I am having difficulties with these household tasks.

Are there day to day living duties which are painful or difficult for you to perform as a result of the injuries you sustained in the motor vehicle collision?

_____
_____
_____

First Choice Family chiropractic Rehab & Massage

Auto Accident Insurance Information

Insurance Company: _____
(for the vehicle YOU were in)
Assigned Adjustor: _____

Policy #: _____

Claim #: _____

If you are not the policy holder for this insurance, please provide the following information.

Policy holder's Name: _____

Policy holder's relation to you: _____

Policy holder's date of birth: _____

Assignment & Release

I Certify that I, and/or my dependent(s), have insurance coverage with _____
(Name of insurance company)
and assign directly to Dr. April Stratford/Dr. Jeff Stratford all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed for one year from date signed below.

Signature of Patient, Parent, Guardian or Personal Representative:

_____

Print name of Patient, Parent, Guardian or Personal Representative:

_____

Date: _____ Relationship to patient: _____

First Choice Family chiropractic Rehab & Massage

INFORMED CONSENT FOR EXAMINATION AND TREATMENT

I (We) hereby consent to the performance of examination and treatment on me or on _____ by the licensed doctors of chiropractic, medical doctors; and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to: fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

Date of last menstrual period: _____.

_____ _____

Patient's Name (Printed) Patient's Signature

_____ _____

Date Relationship or authority if not signed by patient

_____

Witness

NO SHOW AND CANCELLATION POLICY
$30.00 FEE IF YOU NO SHOW

Cancellation of an appointment
If it is necessary to cancel your scheduled appointment, we ask that you call 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to cancel your appointment
To cancel your appointment, please call (478) 272-1800.

No show policy
A “no show” is someone who misses an appointment without cancelling it 24 hours in advance of the scheduled appointment. No shows inconvenience those individuals who need who need access to medical care in a timely manner. Failure to arrive on time to your scheduled appointment will be recorded in your chart as a “no show”. The first time there is a “no show” you will be called and informed of the appointment so that we may reschedule. If there is a second “no show”, a fee of $30.00 will be billed to you. Your insurance company **WILL NOT** pay this. This fee will cover administrative tasks associated with your appointment. This fee must be paid before scheduling any further appointments.

BY SIGNING BELOW I ACKNOWLEDGE RECEIPT AND WILL ABIDE BY THE NO SHOW AND CANCELLATION POLICY.

Signature: _____ Date: _____

Print Name: _____

Personal Injury Financial Policy

To the best of my knowledge, all information above is accurate and true. I authorize my insurance carrier(s), trustees, executors, accountant, custodian &/or attorney to make payment directly to First Choice Family Chiropractic for services rendered to me/my family by First Choice Family Chiropractic. I agree to pay any balance left unpaid. I authorize First Choice Family Chiropractic to send bills/claims &/or reports for services rendered directly to my insurance carrier &/or attorney and to release to my insurance carrier &/or attorney any information needed to process my claim. I acknowledge that I am completely and fully responsible for paying all fees that I or my family incurs with First Choice Family Chiropractic. If I have financial difficulties/hardship, I shall pay First Choice Family Chiropractic according to the terms of any agreement that I make with First Choice Family Chiropractic. This authorization serves as a Doctor's Lien, directing my attorney to withhold any settlement, judgment or verdict which may be paid to my attorney or me whatever sum is needed to protect First Choice Family Chiropractic, and to pay First Choice Family Chiropractic directly from those proceeds. If First Choice Family Chiropractic has to resort to collection or court proceedings against me, I agree to pay all collection and/or court cost, including the fees of collections agents, attorneys, and court costs, in addition to paying all fees due to First Choice Family Chiropractic for services rendered by First Choice Family Chiropractic to &/or for me or my family. I authorized First Choice Family Chiropractic and staff to call me on the telephone to discuss appointments, treatment information, and/or any other details related to my/my family's therapy and treatment. First Choice Family Chiropractic and staff may leave messages about appointments on my answering machine. If I am unavailable or incapacitated, I authorize First Choice Family Chiropractic and/or staff to discuss my case with my spouse, parents, adult children, and/or other health care providers. First Choice Family Chiropractic is authorized to release any and all information requested to any other health care provider involved in my care and treatment.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to PI patients:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.
4. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim until after your care is completed. After settlement, your balance will be due. If First Choice Family Chiropractic has to resort to debt collection I understand that I am responsible for any fees used to obtain my debt. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

_____ (initial) I have read and understand the terms and conditions stated above. If I needed any help, I asked staff to read and explain all details concerning the above document.

_____ (initial) I have answered all questions completely and honestly to the best of my knowledge.

Today's Date _____

Patient's Signature _____

Patient's Printed Name _____

Witness _____