

PATIENT NAME:
DOS:

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ M.I.: _____ SSN: _____

SEX: MALE
 FEMALE

DATE OF BIRTH: _____

AGE: _____

DOMINANCE: RIGHT HANDED
 LEFT HANDED
 AMBIDEXTROUS

PHONE NUMBER: _____

FAX NUMBER: _____

MOBILE NUMBER: _____

ADDRESS 1: _____

ADDRESS 2: _____

CITY: _____

STATE: _____

ZIP CODE: _____

INSURANCE: _____

POLICY NUMBER: _____ CLAIM NUMBER: _____

ATTORNEY: _____

REFERRING DOCTOR: _____

EMPLOYER: _____

PATIENT NAME:
DOS:

DETAILS

DATE OF SERVICE: _____

- INITIAL EVALUATION
- FOLLOW-UP EVALUATION
- FINAL EVALUATION

TYPE OF ACCIDENT: AUTOMOBILE
 WORKERS COMPENSATION
 SLIP AND FALL

IN HIS/HER OWN WORDS, THE PATIENT DESCRIBES THE ACCIDENT/HISTORY OF PRESENT ILLNESS:

DATE OF ACCIDENT: _____

THE PATIENT'S POSITION WAS: DRIVER
 FRONT PASSENGER
 LEFT REAR PASSENGER
 RIGHT REAR PASSENGER
 MIDDLE FRONT PASSENGER
 MIDDLE REAR PASSENGER

TIME OF THE ACCIDENT: _____:_____ AM/PM

LOCATION OF ACCIDENT: _____

PATIENT'S VEHICLE SPEED: _____ MPH

OTHER VEHICLE SPEED: _____ MPH

DAMAGE TO PATIENT'S VEHICLE: MILD
 MODERATE
 EXTENSIVE
 TOTALED

VISIBILITY: POOR
 FAIR
 GOOD

THE WEATHER WAS: SNOWING RAINING WINDY
 FOGGY CLEAR

WHO HIT WHO/WHAT: PATIENT HIT OTHER VEHICLE
 OTHER VEHICLE HIT PATIENT
 PATIENT HIT OTHER OBJECT

POINT OF IMPACT: FRONT LEFT FRONT RIGHT FRONT
 REAR LEFT REAR RIGHT REAR
 LEFT SIDE RIGHT SIDE

WAS THE PATIENT USING THE SEATBELT? YES NO

WAS THE PATIENT USING THE SHOULDER HARNESS? YES NO

DOES THE VEHICLE HAVE AN AIRBAG YES NO

WAS THE AIRBAG DEPLOYED? YES NO

DID THE PATIENT STRIKE ANYTHING ON THE VEHICLE? YES NO

IF YES, WHAT? WHEEL WINDSHIELD ARMREST
 DASHBOARD SIDE DOOR SIDE WINDOW
 AIRBAG

WHERE? (PART OF THE BODY): _____

DID THE PATIENT SEE THE ACCIDENT COMING? YES NO

DOES THE VEHICLE HAVE HEADREST? YES NO

WHAT POSITION? EVEN WITH TOP OF HEAD
 EVEN WITH BOTTOM OF HEAD
 MIDDLE OF NECK

WAS THE PATIENT BRACED FOR THE IMPACT? YES NO

WAS THE PATIENT DAZED? YES NO

DID THE PATIENT LOSE CONSCIOUSNESS? YES NO

IF YES, FOR HOW LONG? _____

DIRECTION OF HEAD: EVEN WITH TOP OF HEAD
 EVEN WITH BOTTOM OF HEAD
 MIDDLE OF NECK

WAS THE HEAD INJURED? YES NO

OTHER PART INJURED: _____

IMMEDIATELY AFTER THE ACCIDENT, PATIENT EXPERIENCED:

HEADACHES NECK PAIN LOW BACK PAIN
 OTHER: _____

DID THE PATIENT GO TO THE HOSPITAL? YES NO

WHAT HOSPITAL: _____

TRANSPORTATION TO HOSPITAL BY: AMBULANCE
 DROVE SELF
 SOMEBODY ELSE
 POLICE

TEST DONE AT THE HOSPITAL:

X-RAYS MRI CT-SCAN LAB WORK
 OTHER TEST: _____

ANY PRIOR DOCTOR FOR THIS ACCIDENT? YES NO

NAME: DR. _____

TESTS PERFORMED _____

NAME 2: DR. _____

TESTS PERFORMED _____

NAME 3: DR. _____

TESTS PERFORMED _____

PATIENT NAME:
DOS:

SINCE THE ACCIDENT IS THE PATIENT:
 BETTER SAME WORSE

HAS THE PATIENT LOST TIME FROM WORK? YES NO

IF YES, FOR HOW LONG? _____

CAN PERFORM PHYSICAL WORK ACTIVITIES? YES NO

IF NO, WHY? PAIN WEAKNESS STRESS

OTHER: _____

SINCE THE ACCIDENT HAS HAD PROBLEMS WITH:

- SEEING TASTING SMELLING EATING
- HEARING BATHING GROOMING DRESSING
- READING TYPING WRITING GRASPING
- HOLDING PINCHING STANDING LEANING
- WALKING STOOPING SQUATTING CLIMBING
- KNEELING BENDING TWISTING CARRYING
- LIFTING PUSHING PULLING REACHING
- SITTING DRIVING RIDING CAR PLANE TRAV.
- SPORTS EXERCISING LOSS OF SEXUAL DRIVE
- RECLINING RESTFUL SLEEPING
- INSOMNIA USING THE TOILET
- LOSS OF CONCENTRATION NERVOUS IRRITABLE
- CHANGE IN PERSONALITY TACTILE FEELING

CAN GO TO SLEEP WITHOUT PROBLEMS? YES NO

AWAKEN BECAUSE OF PAIN? YES NO

IF YES, WHERE? _____

HAD SLEEP PROBLEMS BEFORE? YES NO

PATIENT'S OCCUPATION: _____

DUTY: LIGHT DUTY
 REGULAR DUTY

FINANCIAL BURDEN FOR PATIENT AND FAMILY? YES NO

IF YES, PATIENT EXPLAINS: _____

HAS BEEN IN AN ACCIDENT BEFORE? YES NO

IF YES, IN (YEAR) _____

DOCTOR WHO TREATED, DR. YES NO

DETAILS: _____

ANY RESIDUAL PROBLEMS? YES NO

EXPLAIN: _____

SECOND ACCIDENT

IF YES, IN (YEAR) _____

DOCTOR WHO TREATED, DR. _____

DETAILS: _____

ANY RESIDUAL PROBLEMS? YES NO

EXPLAIN: _____

THIRD ACCIDENT

IF YES, IN (YEAR) _____

DOCTOR WHO TREATED, DR. _____

DETAILS: _____

ANY RESIDUAL PROBLEMS? YES NO

EXPLAIN: _____

PATIENT NAME: _____

DOS: _____

COMPLAINT 1: _____

GRADE: _____

CAME ON: GRADUALLY
 IMMEDIATELY

IT IS GETTING BETTER
 SAME
 WORSE

INTENSITY: MINIMAL
 SLIGHT
 MODERATE
 SEVERE

FREQUENCY: INTERMITTENT
 OCASSIONAL
 FREQUENT
 CONSTANT

DESCRIBE FEELING: DULL SHARP ACHING SHOOTING SPASM THROBBING BURNING
 NUMBING TINGLING
OTHER: _____

LOCATION: RIGHT LEFT ANTERO-LATERAL POSTERO-LATERAL

ACTIONS EFFECTING THIS PAIN:

(B) BRINGS ON (A) AGRAVATES (R) RELIEVES

IN THE MORNING: B A R
BENDING BACK: B A R
TWISTING RIGHT: B A R
SNEEZING: B A R
LIFTING: B A R
COLD: B A R
MEDICATIONS: B A R

IN THE AFTERNOON: B A R
BENDING LEFT: B A R
TWISTING LEFT: B A R
STRAINING: B A R
SITTING: B A R
REST: B A R

BENDING FORWARD: B A R
BENDING RIGHT: B A R
COUGHING: B A R
STANDING: B A R
HEAT: B A R
LYING DOWN: B A R

NOTHING RELIEVES THE PAIN

OTHER 1: _____ B A R
OTHER 2: _____ B A R

PAIN RADIATES TO:

HEAD: RIGHT LEFT | NECK: RIGHT LEFT | SHOULDER: RIGHT LEFT
ARM: RIGHT LEFT | HAND: RIGHT LEFT | HIP: RIGHT LEFT
LEG: RIGHT LEFT | FOOT: RIGHT LEFT

PAIN ALSO RADIATES TO: _____

ADDITIONAL COMMENTS: _____

COMPLAINT 2: _____

GRADE: _____

CAME ON: GRADUALLY
 IMMEDIATELY

IT IS GETTING BETTER
 SAME
 WORSE

INTENSITY: MINIMAL
 SLIGHT
 MODERATE
 SEVERE

FREQUENCY: INTERMITTENT
 OCASSIONAL
 FREQUENT
 CONSTANT

DESCRIBE FEELING: DULL SHARP ACHING SHOOTING SPASM THROBBING BURNING
 NUMBING TINGLING
OTHER: _____

LOCATION: RIGHT LEFT ANTERO-LATERAL POSTERO-LATERAL

ACTIONS EFFECTING THIS PAIN:

(B) BRINGS ON (A) AGRAVATES (R) RELIEVES

IN THE MORNING: B A R
BENDING BACK: B A R
TWISTING RIGHT: B A R
SNEEZING: B A R
LIFTING: B A R
COLD: B A R
MEDICATIONS: B A R

IN THE AFTERNOON: B A R
BENDING LEFT: B A R
TWISTING LEFT: B A R
STRAINING: B A R
SITTING: B A R
REST: B A R

BENDING FORWARD: B A R
BENDING RIGHT: B A R
COUGHING: B A R
STANDING: B A R
HEAT: B A R
LYING DOWN: B A R

NOTHING RELIEVES THE PAIN

OTHER 1: _____ B A R
OTHER 2: _____ B A R

PAIN RADIATES TO:

HEAD: RIGHT LEFT | NECK: RIGHT LEFT | SHOULDER: RIGHT LEFT
ARM: RIGHT LEFT | HAND: RIGHT LEFT | HIP: RIGHT LEFT
LEG: RIGHT LEFT | FOOT: RIGHT LEFT

PAIN ALSO RADIATES TO: _____

ADDITIONAL COMMENTS: _____

PATIENT NAME:
DOS:

> **COMPLAINT 3:** _____

GRADE: _____

CAME ON: GRADUALLY
 IMMEDIATELY

IT IS GETTING BETTER
 SAME
 WORSE

INTENSITY: MINIMAL
 SLIGHT
 MODERATE
 SEVERE

FREQUENCY: INTERMITTENT
 OCASSIONAL
 FREQUENT
 CONSTANT

DESCRIBE FEELING: DULL SHARP ACHING SHOOTING SPASM THROBING BURNING
 NUMBING TINGLING
OTHER: _____

LOCATION: RIGHT LEFT ANTERO-LATERAL POSTERO-LATERAL

ACTIONS EFFECTING THIS PAIN:

(B) BRINGS ON (A) AGRAVATES (R) RELIEVES

IN THE MORNING: B A R
BENDING BACK: B A R
TWISTING RIGHT: B A R
SNEEZING: B A R
LIFTING: B A R
COLD: B A R
MEDICATIONS: B A R
 NOTHING RELIEVES THE PAIN

IN THE AFTERNOON: B A R
BENDING LEFT: B A R
TWISTING LEFT: B A R
STRAINING: B A R
SITTING: B A R
REST: B A R

BENDING FORWARD: B A R
BENDING RIGHT: B A R
COUGHING: B A R
STANDING: B A R
HEAT: B A R
LYING DOWN: B A R

OTHER 1: _____ B A R
OTHER 2: _____ B A R

PAIN RADIATES TO:

HEAD: RIGHT LEFT | NECK: RIGHT LEFT | SHOULDER: RIGHT LEFT
ARM: RIGHT LEFT | HAND: RIGHT LEFT | HIP: RIGHT LEFT
LEG: RIGHT LEFT | FOOT: RIGHT LEFT

PAIN ALSO RADIATES TO: _____

ADDITIONAL COMMENTS: _____

> **COMPLAINT 4:** _____

GRADE: _____

CAME ON: GRADUALLY
 IMMEDIATELY

IT IS GETTING BETTER
 SAME
 WORSE

INTENSITY: MINIMAL
 SLIGHT
 MODERATE
 SEVERE

FREQUENCY: INTERMITTENT
 OCASSIONAL
 FREQUENT
 CONSTANT

DESCRIBE FEELING: DULL SHARP ACHING SHOOTING SPASM THROBING BURNING
 NUMBING TINGLING
OTHER: _____

LOCATION: RIGHT LEFT ANTERO-LATERAL POSTERO-LATERAL

ACTIONS EFFECTING THIS PAIN:

(B) BRINGS ON (A) AGRAVATES (R) RELIEVES

IN THE MORNING: B A R
BENDING BACK: B A R
TWISTING RIGHT: B A R
SNEEZING: B A R
LIFTING: B A R
COLD: B A R
MEDICATIONS: B A R
 NOTHING RELIEVES THE PAIN

IN THE AFTERNOON: B A R
BENDING LEFT: B A R
TWISTING LEFT: B A R
STRAINING: B A R
SITTING: B A R
REST: B A R

BENDING FORWARD: B A R
BENDING RIGHT: B A R
COUGHING: B A R
STANDING: B A R
HEAT: B A R
LYING DOWN: B A R

OTHER 1: _____ B A R
OTHER 2: _____ B A R

PAIN RADIATES TO:

HEAD: RIGHT LEFT | NECK: RIGHT LEFT | SHOULDER: RIGHT LEFT
ARM: RIGHT LEFT | HAND: RIGHT LEFT | HIP: RIGHT LEFT
LEG: RIGHT LEFT | FOOT: RIGHT LEFT

PAIN ALSO RADIATES TO: _____

ADDITIONAL COMMENTS: _____

PATIENT NAME:
DOS:

> **COMPLAINT 5:** _____

GRADE: _____

CAME ON: GRADUALLY
 IMMEDIATELY

IT IS GETTING BETTER
 SAME
 WORSE

INTENSITY: MINIMAL
 SLIGHT
 MODERATE
 SEVERE

FREQUENCY: INTERMITTENT
 OCASSIONAL
 FREQUENT
 CONSTANT

DESCRIBE FEELING: DULL SHARP ACHING SHOOTING SPASM THROBING BURNING
 NUMBING TINGLING
OTHER: _____

LOCATION: RIGHT LEFT ANTERO-LATERAL POSTERO-LATERAL

ACTIONS EFFECTING THIS PAIN:

(B) BRINGS ON (A) AGRAVATES (R) RELIEVES

IN THE MORNING: B A R
BENDING BACK: B A R
TWISTING RIGHT: B A R
SNEEZING: B A R
LIFTING: B A R
COLD: B A R
MEDICATIONS: B A R
 NOTHING RELIEVES THE PAIN

IN THE AFTERNOON: B A R
BENDING LEFT: B A R
TWISTING LEFT: B A R
STRAINING: B A R
SITTING: B A R
REST: B A R

BENDING FORWARD: B A R
BENDING RIGHT: B A R
COUGHING: B A R
STANDING: B A R
HEAT: B A R
LYING DOWN: B A R

OTHER 1: _____ B A R
OTHER 2: _____ B A R

PAIN RADIATES TO:

HEAD: RIGHT LEFT | NECK: RIGHT LEFT | SHOULDER: RIGHT LEFT
ARM: RIGHT LEFT | HAND: RIGHT LEFT | HIP: RIGHT LEFT
LEG: RIGHT LEFT | FOOT: RIGHT LEFT

PAIN ALSO RADIATES TO: _____

ADDITIONAL COMMENTS: _____

> **COMPLAINT 6:** _____

GRADE: _____

CAME ON: GRADUALLY
 IMMEDIATELY

IT IS GETTING BETTER
 SAME
 WORSE

INTENSITY: MINIMAL
 SLIGHT
 MODERATE
 SEVERE

FREQUENCY: INTERMITTENT
 OCASSIONAL
 FREQUENT
 CONSTANT

DESCRIBE FEELING: DULL SHARP ACHING SHOOTING SPASM THROBING BURNING
 NUMBING TINGLING
OTHER: _____

LOCATION: RIGHT LEFT ANTERO-LATERAL POSTERO-LATERAL

ACTIONS EFFECTING THIS PAIN:

(B) BRINGS ON (A) AGRAVATES (R) RELIEVES

IN THE MORNING: B A R
BENDING BACK: B A R
TWISTING RIGHT: B A R
SNEEZING: B A R
LIFTING: B A R
COLD: B A R
MEDICATIONS: B A R
 NOTHING RELIEVES THE PAIN

IN THE AFTERNOON: B A R
BENDING LEFT: B A R
TWISTING LEFT: B A R
STRAINING: B A R
SITTING: B A R
REST: B A R

BENDING FORWARD: B A R
BENDING RIGHT: B A R
COUGHING: B A R
STANDING: B A R
HEAT: B A R
LYING DOWN: B A R

OTHER 1: _____ B A R
OTHER 2: _____ B A R

PAIN RADIATES TO:

HEAD: RIGHT LEFT | NECK: RIGHT LEFT | SHOULDER: RIGHT LEFT
ARM: RIGHT LEFT | HAND: RIGHT LEFT | HIP: RIGHT LEFT
LEG: RIGHT LEFT | FOOT: RIGHT LEFT

PAIN ALSO RADIATES TO: _____

ADDITIONAL COMMENTS: _____

PATIENT NAME:
DOS:

PAST MEDICAL HISTORY

PAST MEDICAL HISTORY 1: _____
PAST MEDICAL HISTORY 2: _____
PAST MEDICAL HISTORY 3: _____
PAST MEDICAL HISTORY 4: _____
PAST MEDICAL HISTORY 5: _____

PAST SURGICAL HISTORY

PAST SURGICAL HISTORY 1: _____
PAST SURGICAL HISTORY 2: _____
PAST SURGICAL HISTORY 3: _____
PAST SURGICAL HISTORY 4: _____
PAST SURGICAL HISTORY 5: _____

ALLERGIES

ALLERGIES 1: _____
ALLERGIES 2: _____
ALLERGIES 3: _____
ALLERGIES 4: _____
ALLERGIES 5: _____

SOCIAL HISTORY

MARITAL STATUS: MARRIED SINGLE CHILDREN: _____ PREGNANT? YES NO IF YES, _____ MONTHS
WIDOWED DIVORCED
SEPARATED

PATIENT REPORTS THE USE OF: TOBACCO ALCOHOL COFFEE OTHER: _____

PAST FAMILY HISTORY

PAST FAMILY HISTORY 1: _____
PAST FAMILY HISTORY 2: _____
PAST FAMILY HISTORY 3: _____
PAST FAMILY HISTORY 4: _____
PAST FAMILY HISTORY 5: _____

CURRENT MEDICATIONS

CURRENT MEDICATIONS 1: _____
CURRENT MEDICATIONS 2: _____
CURRENT MEDICATIONS 3: _____
CURRENT MEDICATIONS 4: _____
CURRENT MEDICATIONS 5: _____

Patient Signature: _____ Date: _____

PATIENT CONSENT FORM (HIPPA)

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The privacy rule was also created in order to provide standards for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal records and will do all we can to secure and protect the privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary to only those we feel are in need of your healthcare information and information about treatment, payment or health care operations, in order to provide healthcare that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or healthcare operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke the actions that have already been take which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak to our HIPPA Compliance Officer. This office does not give any information on a patient without authorization from the patient.

Print Name: _____ **Signature:** _____ **Date:** _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability Act (HIPPA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest of standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to insure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization, if they feel that an event in any was compromise our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the solution promptly.

Thank you for being one of our highly valued patients!

Terms of Acceptance

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working towards the same goals. Chiropractic has only one goal: **To locate, analyze, and correct spinal interference to the nervous system i.e. subluxation.** It is important that each patient understand both the objective and method(s) used to attain it. This will prevent any confusion or disappointment.

Adjustment: the specific application of forces to facilitate the body’s correction of vertebral subluxation. Our chiropractic method is by specific adjustments to the spine.

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

Vertebral Subluxation: a misalignment of one or more of the 24 vertebra 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. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or “unusual” findings, we will notify you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a healthcare provider that specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our only practice objective** is to eliminate interference to the nervous system, caused by vertebral subluxation, allowing the body to function at its optimal potential

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic, Aaron G. Wines and/or other licensed doctors of chiropractic who now or in the future work at Active Chiropractic Health & Wellness.

I have had an opportunity to discuss with the doctor of chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

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, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, 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 condition(s) for which I seek treatment.

Patient Name _____

Patient Signature _____ Date _____

Witness Signature _____ Date _____

X-Ray Consent Form

The purpose of the x-ray examination to be performed is to analyze the spine for vertebral subluxation, rate and level of degeneration of the spine, and to determine the appropriateness of spinal adjustments. I fully understand the above and consent to chiropractic spinal x-rays.

Patient Name _____

Patient Signature _____

Date _____

Pregnancy Release: This is to certify that to the best of my knowledge I am not pregnant and Active Chiropractic Health & Wellness has my permission to perform an x-ray evaluation. I understand the risks of taking an x-ray to an unborn child.

Date of last menstrual period ____/____/____

Patient Signature _____ Date _____