Patient Name: ____________________________

Personal Injury Intake Form

Informed Consent | Financial Policy | Privacy Policy

Date________________

☐MWP_________ ☐PI ☐WC ☐VA ☐MEDICARE ☐INS

Full Name______________________________ **Preferred Name**_____________________________ **Date of Birth** ______________

Address____ **City**__________________________ **State**____________ **Zip** ______________

Sex ☐ Male ☐ Female **Marital Status** ☐ M ☐ S ☐ W ☐ D **Number of Children?** _______

Cell Phone _________________________ **Home Phone** _____________________ **E-mail** _____________________________________

Preferred method of communication. ☐ Cell Phone ☐ Home Phone ☐ E-mail ☐ Other ___________________________________

Are you being represented by a Lawyer? ☐ No ☐ Yes Name_________________________ Phone_______________________________

How did you hear about us? _______________________ **Employer**_______________________ **Work Phone**___________________

Name of Spouse/Significant Other____ **Phone** ______________________

Emergency Contact _____________________________ **Relationship** ___________________ **Phone** ______________________

CONSENT TO CHIROPRACTIC EXAMINATION AND TREATMENT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in it. Please ask questions if there is anything that is unclear before you sign.

Information about the Chiropractic Adjustment
The primary treatment used in the clinic is spinal manipulative therapy or the chiropractic adjustment. It is likely that spinal manipulative therapy will be used as part of your treatment. Spinal manipulative therapy includes placement of the doctor's hands or mechanical instruments upon your body in such a way as to mobilize your joints. This movement may cause an audible "pop" or "click," such as experienced when you "crack" your knuckles. You may also feel a sense of movement.

The Material Risks Inherent in the Chiropractic Adjustment
All patient care, including chiropractic treatment, has the potential for negative effects. The risks associated with chiropractic treatments include, but are not limited to, dislocations and sprains, disc injuries, fractures, and strokes. These negative effects are very rare but nevertheless exist. The Doctors at ChiroTrendz Family Chiropractic and Wellness Center will develop a treatment plan recommending what they feel is in your best interest based on clinical examination, patient history, and professional experience.

The Probability of Those Risks Occurring
Fractures are rare occurrences and generally result from some underlying weakness of the bone which your doctor looks for during your initial consultation, examination, and while reviewing your x-rays if indicated or recommended. Stroke has been the subject of tremendous disagreement. The incidence of a stroke is exceedingly rare and is estimated to occur between one in one million and one in five million adjustments of the neck. The other complications are also generally described as rare.

The Availability and Nature of Other Treatment Options
Other treatment options for your condition may include: Self-administered, over-the-counter analgesics and rest, Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers, Hospitalization, and Surgery
If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary care physician.

Overuse of over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient’s overall health, severity of discomfort, their pain tolerance, and their self-discipline in not abusing the medication.

Professional literature describes highly undesirable effects from long term use of over-the-counter medications.

Prescription muscle relaxants and pain killers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's overall health, severity of discomfort, their pain tolerance, their self-discipline in not abusing the medication, and proper professional supervision. Such medications generally entail very significant risks – some with rather high probabilities.

Hospitalization in conjunction with other care, bears the additional risk of exposure to communicable diseases, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain; exposure to communicable disease is likely with adverse results from such exposure being dependent upon many variables.

The risks inherent with surgery include adverse reaction to anesthesia, iatrogenic (doctor induced) mishap, all risks associated with hospitalization, and an extended convalescent period. The probability of those risks occurring varies to many factors.

The Risks and Dangers Attendant to Remaining Untreated
Remaining untreated may allow the formation of adhesions and reduce mobility of your joints which may set up a pain reaction further reducing mobility and overall range of motion. Over time this process may compromise your recovery making treatment more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

The Chiropractic Examination
Prior to establishing a treatment plan, the doctor must perform a Chiropractic Examination in order to determine the probable cause of your complaint. During the examination the doctor will perform some procedures or maneuvers intended to reproduce your symptoms which will allow for a better understanding of the nature of your condition and for the development of an appropriate treatment regimen. There is a slight possibility that these maneuvers may temporarily aggravate your symptoms.

Documented Patient Noncompliance
Every effort will be made to help you achieve maximum health. It is important to keep your appointments and follow through with the prescribed treatment plan. We understand busy schedules and anticipate these as a part of life, however, please be courteous and inform us of any conflicts in scheduling immediately so that we may accommodate you accordingly and schedule other patients in need. If the noncompliance reaches the point of jeopardizing "good quality care," we may formally discharge you as a patient with an appropriate letter of withdrawal. Your patient records will note such problems of noncompliance and you will be provided an alternative source of recovery.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me the above explanations regarding the chiropractic examination, adjustment, and related treatment and have discussed it with the Doctors at ChiroTrendz Family Chiropractic and Wellness Center and have had my questions answered to my satisfaction.

By signing below I state that I understand the benefits, risks, and alternatives involved in undergoing treatment and have decided that it is in my best interest or my child's best interest to undergo the treatment recommended by the Doctors at ChiroTrendz Family Chiropractic and Wellness Center. Having been informed of the benefits, risks, and alternatives, I hereby give my consent to the prescribed and recommended treatment. I intend this consent to cover any examinations and treatments for my present condition and for any future conditions for which I seek treatment from ChiroTrendz Family Chiropractic and Wellness Center.

If the patient is a minor, I hereby authorize the doctors and staff at ChiroTrendz Family Chiropractic and Wellness Center to examine my child and to treat his/her condition as deemed appropriate, which may or may not include diagnostic imaging.

Date __________

Date __________

____
Printed Name of Patient *or* Parent/Guardian (if a minor)

DOCTOR OF RECORD
Jason McDonald, DC Kolby Wolfley, DC

____
Signature of Patient *or* Parent/Guardian (if a minor)

____
Signature of Doctor

ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

I acknowledge that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that ChiroTrendz Family Chiropractic and Wellness Center will help 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 ChiroTrendz Family Chiropractic and Wellness Center will be added to my account.

I hereby assign all medical and chiropractic benefits to which I am entitled to ChiroTrendz Family Chiropractic and Wellness Center. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other medical plan or representative to issue payment check(s) or direct deposits directly to ChiroTrendz Family Chiropractic and Wellness Center for medical or chiropractic services rendered to myself and/or my dependents.

I acknowledge that ChiroTrendz Family Chiropractic and Wellness Center **CAN NOT** guarantee that my insurance company will pay. Prior to or immediately after my first visit, ChiroTrendz will make every attempt to receive and verify benefits and coverage. I understand that if I seek treatment outside of ChiroTrendz Family Chiropractic and Wellness Center, my remaining benefits may not be accurate and claims may be denied due to exhausted benefits.

I acknowledge that I will communicate to ChiroTrendz Family Chiropractic and Wellness Center when I see another Chiropractor from another facility while under a current treatment plan at ChiroTrendz Family Chiropractic and Wellness Center. I understand that insurance claims may be denied if I see multiple providers for the same injury or complaint.

Name of Current Chiropractor____ Date Last Seen: _________________

□ First Time Chiropractic patient □ Terminated Care at previous Chiropractor □ Simultaneous Care

I acknowledge that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that I am responsible for any amount not covered by insurance. I also understand that if I suspend or terminate my care and treatment or insurance policy, any fees for professional services rendered to me will be immediately due and payable.

I acknowledge that a Medical Lien will be filed with all involved 3rd party payers and legal representatives, regardless of fault, for all Personal Injury cases to ensure that all my treatments and visits are covered by the appropriate entity. I understand that a Medical Lien will be filed in Maricopa County, Arizona on behalf of ChiroTrendz Family Chiropractic and Wellness Center for all ongoing medical expenses accrued in the office. I understand that a copy of the lien will be provided when filed. I acknowledge that any changes to this process must be discussed and agreed upon within 30 days. Please seek legal counsel relative to this financial policy.

____	____	__________
Printed Name of Patient *or* Parent/Guardian (if a minor)	Signature of Patient *or* Parent/Guardian (if a minor)	Date

ACKNOWLEDGEMENT OF REVIEW OF PRIVACY PRACTICES

I have reviewed ChiroTrendz Family Chiropractic and Wellness Center's Notice of Privacy Practices, which explains how my Protected Health Information (PHI) will be used and disclosed. I have had my questions satisfactorily answered considering this policy. I understand that I am entitled to receive a copy of this document upon request at any time. I also acknowledge that I may review the policy anytime online at *http://www.chirotrendz.com/privacy.html*.

I hereby grant ChiroTrendz Family Chiropractic and Wellness Center the right to post my feedback and testimonial of care on social media and company websites when I leave such feedback. If you do not want your feedback posted please let us know at any time and we will remove it.

____	____	__________
Printed Name of Patient *or* Parent/Guardian (if a minor)	Signature of Patient *or* Parent/Guardian (if a minor)	Date

-- FOR OFFICE USE ONLY--

ChiroTrendz LLC attempted to obtain written acknowledgment of receipt or review of our Notice of Privacy Practices, but acknowledgment could not be obtained because (please specify) ____

Staff Signature ____ Date _____________________________

Patient Name: ______________________________

List and describe your major complaints	How long?	Rate your pain
		0 1 2 3 4 5 6 7 8 9 10
		0 1 2 3 4 5 6 7 8 9 10
		0 1 2 3 4 5 6 7 8 9 10
		0 1 2 3 4 5 6 7 8 9 10
		0 1 2 3 4 5 6 7 8 9 10
		0 1 2 3 4 5 6 7 8 9 10

Have you been treated yet? □ Y □ N Explain:

What makes your condition BETTER?

What makes your condition WORSE?

Does the pain/numbness RADIATE? □ Y □ N Explain:

What time of day is your condition BETTER? **What time of day is your condition WORSE?** □ **Same all day**

Does your condition interfere with any of the following: □ Work □ Sleep □ Recreation □ Social life □ Family life

Have you had this condition in the past? □ Y □ N Explain:

Date of last Chiropractic treatment? **Name of previous chiropractor?**

MEDICAL HISTORY: Describe any of the following. Provide approximate dates. □ PD

Infections: ______________________________ Major Trauma: ______________________________
Hospitalizations: ______________________________ Spinal or neck injuries: ______________________________
Automobile/Motorcycle accidents: ______________________ Surgeries: ______________________________
Falls or other injuries: __________________________ Other: ______________________________

FAMILY MEDICAL HISTORY: Describe any medical issues in your family. Provide approximate dates. □ PD

Mother: ______________________________ Father: ______________________________
Sister(s): ______________________________ Brother(s): ______________________________
Maternal Grandmother: ______________________ Paternal Grandmother: ______________________
Maternal Grandfather: ______________________ Paternal Grandfather: ______________________

SOCIAL HISTORY:

Tobacco Use: □ Y □ N Pack(s)/day____
□ Former Start ________ End _________
Alcohol Use: □ Y □ N ______ Drinks/Day
Recreational Drug Use □ Y □ N
Daily Water Intake ______________

Exercise ____ Hours/day
Sleep ____ Hours/day
Computer Use ____ Hours/day
TV/Video Games ____ Hours/day
Cell Phone Use ____ Hours/day

Rate your DIET 0 1 2 3 4 5 6 7 8 9 10
Rate Stress at HOME 0 1 2 3 4 5 6 7 8 9 10
Rate Stress at WORK 0 1 2 3 4 5 6 7 8 9 10
Rate Stress at SCHOOL 0 1 2 3 4 5 6 7 8 9 10
Stress Outlets ________________

LIST ALL MEDICATIONS and NUTRITIONAL SUPPLEMENTS **DOSAGE** **REASON FOR TAKING** □ PD

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

Do you have any Drug Allergies/Interactions? □ Y □ N Explain ______________________________
Do you have any other Allergies? □ Y □ N Explain ______________________________
Do you have any Food Allergies/Intolerances? □ Y □ N Explain ______________________________

Patient Name: ____________________________

MOTOR VEHICLE ACCIDENT DETAILS

Date of Accident: _________ **Time of Day**: ______
Your position: □Driver □Passenger □Front Seat □Back Seat
Number of people in your vehicle? ___________
Number of people in other vehicle? __________
Were the police notified? □Yes □No
Did an EMT/Paramedic come to the accident? □Yes □No
Did EMT/Paramedic inspect you? □Yes □No
Were you transported via ambulance? □Yes □No

Direction you were headed? □North □East □South □West
Direction of the other vehicle? □North □East □South □West
Where were you struck? □Rear □Front □Drivers Side □Passengers Side
Were you knocked unconscious? □Yes □No
Did you know that you were going to get hit? □Yes □No
Were you wearing a seat belt? □Yes □No
Did airbags deploy? □Yes □No

Please describe details of the accident: ____
____
____
____
____

Did you have any physical complaints BEFORE THE ACCIDENT? □Yes □No **Explain:** ____
____
____

Please describe how you felt:
a) **DURING THE ACCIDENT:** ____
b) **IMMEDIATELY AFTER THE ACCIDENT:** ____
c) **LATER THAT DAY:** ____
d) **THE NEXT DAY:** ____

Where were you taken after the accident? ____

Have you ever been treated by another doctor since the accident? □Yes □No **If yes, please list doctor's name and address:** ____________
____

What type of treatment did you receive? ____

Since this injury occurred, are your symptoms: □Improving □Staying the same □Getting Worse

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT

□Headache	□Irritability	□Numbness in Toes	□Face Flushed	□Cold Feet
□Neck Pain	□Chest Pain	□Shortness of Breath	□Buzzing in Ears	□Cold Hands
□Neck Stiff	□Dizziness	□Fatigue	□Loss of Balance	□Upset Stomach
□Sleeping Problems	□Head seems Too Heavy	□Depression	□Fainting	□Constipation
□Back Pain	□Pins & Needles in Arms	□Light Sensitivity	□Loss of Smell	□Cold Sweats
□Nervousness	□Pins & Needles in Legs	□Loss of Memory	□Loss of Taste	□Fever
□Tension	□Numbness in Fingers	□Ears Ringing	□Diarrhea	□Other_____________

____

Have you lost time from work as a result of this accident? □Yes □No
If yes, please the following questions
a) Last Day Worked: ____
b) Type of Employment: ____

Do you notice any activity restrictions as a result of this injury? □Yes □No **If yes, please describe in detail?** ___________________________
____

Other pertinent information: ____
____

Patient Name: ______________________________

REVIEW OF SYSTEMS

Select the following conditions that apply to you.

Constitutional PD
- ☐ Balance issues
- ☐ Cancer
- ☐ Changes in appetite
- ☐ Changes in sleep
- ☐ Changes in weight
- ☐ Chills
- ☐ Dizziness
- ☐ Fatigue
- ☐ Fever
- ☐ Hyperactivity
- ☐ Tumor
- ☐ Vertigo

Cardiovascular PD
- ☐ Angina/Chest pain
- ☐ Atrial fibrillation (AFib)
- ☐ DVT or Blood Clot
- ☐ Embolism
- ☐ Fainting
- ☐ Hardening of arteries
- ☐ Heart attack
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Stroke
- ☐ Swollen ankles
- ☐ Varicose veins

Respiratory PD
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic cough
- ☐ COPD
- ☐ Difficulty breathing
- ☐ Emphysema
- ☐ Shortness of breath
- ☐ Sleep apnea

Gastrointestinal (GI) PD
- ☐ Acid reflux
- ☐ Belching or gas
- ☐ Celiac Disease
- ☐ Colon issues
- ☐ Constipation
- ☐ Crohn's Disease
- ☐ Diarrhea
- ☐ Gall bladder issues
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Hiatal hernia
- ☐ Jaundice
- ☐ Liver issues
- ☐ Nausea
- ☐ Spitting up blood
- ☐ Stomach aches
- ☐ Stomach ulcers
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary (GU) PD
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stone
- ☐ Painful urination
- ☐ Poor urine control

Musculoskeletal PD
- ☐ Arm pain
- ☐ Arthritis
- ☐ Broken bones
- ☐ Bursitis
- ☐ Elbow pain
- ☐ Foot issues
- ☐ Hip pain
- ☐ Knee pain
- ☐ Leg pain
- ☐ Low backache
- ☐ Muscle atrophy
- ☐ Pain btwn shoulders
- ☐ Painful tailbone
- ☐ Rib Pain
- ☐ Scoliosis
- ☐ Shoulder pain
- ☐ Spinal curvature
- ☐ Sprained ankle
- ☐ Weakness in arms
- ☐ Weakness in legs
- ☐ Wrist pain

Integumentary/Skin PD
- ☐ Bruise easily
- ☐ Eczema/Hives
- ☐ Hair/Nail Changes
- ☐ Itching (Pruritis)
- ☐ Moles (Irregular)
- ☐ Psoriasis
- ☐ Rashes
- ☐ Scaling
- ☐ Skin cancer

Neurological PD
- ☐ Burning sensations
- ☐ Convulsions
- ☐ Numbness in arm/hand
- ☐ Numbness in leg/foot
- ☐ Pins/Needles/Tingling
- ☐ Restless Leg Synd. (RLS)
- ☐ Sciatica
- ☐ Seizures

Psychiatric PD
- ☐ ADHD/ADD
- ☐ Anxiety
- ☐ Dementia
- ☐ Depression
- ☐ Nervousness
- ☐ Paranoia
- ☐ PTSD

Endocrine PD
- ☐ Diabetes Type: ☐ I ☐ II
- ☐ Enlarged Glands
- ☐ Frequent urination
- ☐ Gout
- ☐ Hypoglycemia
- ☐ Swollen joints
- ☐ Thyroid issues

Hematological/Lymphatic PD
- ☐ Anemia
- ☐ Blood disorder

Allergy/Immunologic PD
- ☐ Allergy/Hay Fever
- ☐ Food Allergy/Intolerance
- ☐ Rheumatic fever
- ☐ Tuberculosis

EEMNT PD
- ☐ Dental issues
- ☐ Difficulty swallowing
- ☐ Ear infection(s)
- ☐ Hearing issues
- ☐ Nasal congestion
- ☐ Nosebleeds
- ☐ Ringing in ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ TMJ pain
- ☐ Vision issues ☐ corrected

Head/Neck PD
- ☐ Headaches
- ☐ Migraines ☐ w/ Aura
- ☐ Painful neck
- ☐ Stiff neck

List any other conditions

____

____

____

____

For Women Only PD
- ☐ Breast Augmentation _______
- ☐ Breast Reduction _______
- ☐ Breast lumps or pain
- ☐ Hysterectomy Date: _______
- ☐ Irregular cycle
- ☐ Irregular flow ↑ ↓
- ☐ Menopausal symptoms
- ☐ Menstrual cramps
- ☐ Painful intercourse
- ☐ PCOS
- ☐ Premenstrual tension
- ☐ Tubal ligation Date: ________
- ☐ Unable to get pregnant
- ☐ Vaginal discharge

Last Breast Exam: ___________
Last Pap Smear: ____________
Last Menstrual Period: _______

Regular Checkups? ☐ Yes ☐ No

For Men Only PD
- ☐ Breast lumps or pain
- ☐ Changes in bathroom habits
- ☐ Erectile dysfunction (ED)
- ☐ Low T, Testosterone
- ☐ Painful intercourse
- ☐ Prostate issues
- ☐ Testicular issues
- ☐ Vasectomy Date: _______

Last Prostate Exam: ________
Last Testicular Exam: _______

Regular Checkups? ☐ Yes ☐ No

PD = Patient Denied All Issues
CC = chief complaint
Circle current conditions

____

____

____

____

____

____

____

____

CONFIDENTIAL PROTECTED HEALTH INFORMATION (PHI)

I acknowledge that the health history and demographics above are complete and accurate, and that if any changes in my health or demographics occur, I will discuss these changes with the Doctors at ChiroTrendz Family Chiropractic and Wellness Center.

________________________________	__________	________________________________	__________
Patient Signature *or* Parent/Guardian (if a minor)	Date	Signature of Reviewing Doctor	Date