



chiroTrendz
family chiropractic and wellness center
keeping things in motion

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

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

Kolby Wolfley, DC

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 _____

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: <input type="checkbox"/> Y <input type="checkbox"/> N Pack(s)/day _____ <input type="checkbox"/> Former Start _____ End _____	Exercise _____ Hours/day Sleep _____ 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 _____
Alcohol Use: <input type="checkbox"/> Y <input type="checkbox"/> N _____ Drinks/week Recreational Drug Use <input type="checkbox"/> Y <input type="checkbox"/> N Daily Water Intake _____	Computer Use _____ Hours/day TV/Video Games _____ Hours/day Cell Phone Use _____ Hours/day	

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

- _____
- _____
- _____
- _____
- _____
- _____

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 _____

MOTOR VEHICLE ACCIDENT DETAILS

Date of Accident: _____ Time of Day: _____ Direction you were headed? North East South West
 Your position: Driver Passenger Front Seat Back Seat Direction of the other vehicle? North East South West
 Number of people in your vehicle? _____ Where were you struck? Rear Front Drivers Side Passengers Side
 Number of people in other vehicle? _____ Were you knocked unconscious? Yes No
 Were the police notified? Yes No Did you know that you were going to get hit? Yes No
 Did an EMT/Paramedic come to the accident? Yes No Were you wearing a seat belt? Yes No
 Did EMT/Paramedic inspect you? Yes No Did airbags deploy? Yes No
 Were you transported via ambulance? 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

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Cold Hands |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Upset Stomach |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head seems Too Heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Light Sensitivity | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Ears Ringing | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> 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: _____

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
- Tension
- 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
- 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
- Arm pain
- Arthritis
- Broken bones
- Bursitis
- Elbow pain
- Foot issues
- Hip pain
- Knee pain
- Leg pain
- Low backache

Musculoskeletal PD

- Nausea

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

Neurological PD

- 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

- Anemia PD
- 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

Are you Pregnant? 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 _____

Kolby Wolfley, DC Reviewing Doctor _____ Date _____