Sunset Hills Family Chiropractic
Dr. Brittany Warren • Dr. Robyn Kuhn • Dr. Nathan Free, D.C.
4600 S. Lindbergh Blvd. Suite 3
St. Louis, MO 63127
Phone: 314-729-0027 / 314-843-0300 • Fax: 314-729-1015

Personal Injury Patient Intake Form

Patient's Demographic Information

Patient's full name: _____

Address: _____

Date of Birth: _____

Mailing address (if different): _____

Phone: _____

Employer name: _____

Spouse's Occupation: _____

Employer's address: _____

Work phone: _____

Spouse's name: _____

Spouse's date of birth: _____

Spouse's employer: _____

Occupation: _____

Who May we Thank for your referral? _____

Assignment of Payment

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to Sunset Hills Chiropractic any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay Sunset Hills Chiropractic the difference, if any between the total amount of charges on my account and the amount paid by the attorney and/or insurance carrier. It is further understood that I, the undersigned agree to pay Sunset Hills the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

Patient's signature: _____ Date: _____

Printed name: _____

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Patient Health Questionnaire

Height: _____Weight: _____

Do you exercise? □ Yes □ No Hours per week _____What activities? _____

Are you dieting? □ Yes □ No Since:_____ Do you smoke? □ Yes □ No _____packs per day.

How many years have you been smoking? _____ Do you drink alcoholic beverages? □ Yes □ No _____drinks per day.

Do you wear? □ Heal lifts □ Arch supports □ Prescription Orthotics

For women: Are you pregnant or nursing? □ Yes □ No If pregnant, How many weeks? _____

Date of last menstrual period: _____

List all prescription, non-prescription medications and other supplements you take as well as the associated condition:

_____

_____

_____

List any surgeries or hospitalizations you have had complete with the month and year for each:

_____

_____

_____

List anything you are allergic to: _____

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual):

_____

_____

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History of Treatment

Primary care physician: _____ Phone: _____

Date last seen: _____ May we update them on your condition? ___Yes ____ No

Have you seen a chiropractor before? ____Yes ____ No If yes, name of Chiropractor: _____

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider: _____

_____

Medical History

Describe the reason(s) for your doctor visit today:

_____

_____

_____

_____

Are you here because of an accident? _____What type? _____

When did your symptoms start? _____ How did your symptoms begin? _____

_____

How often do you experience symptoms? (Circle one) Constantly Frequently Occasionally Intermittently

Describe your symptoms? (circle all that apply) Sharp Dull ache Numbing Burning Tingling Shooting

Are your symptoms? (Circle one) Getting better Staying the same Getting worse

How do your symptoms interfere with your work or normal activities?_____

_____

_____

Have you experienced these symptoms in the past?_____

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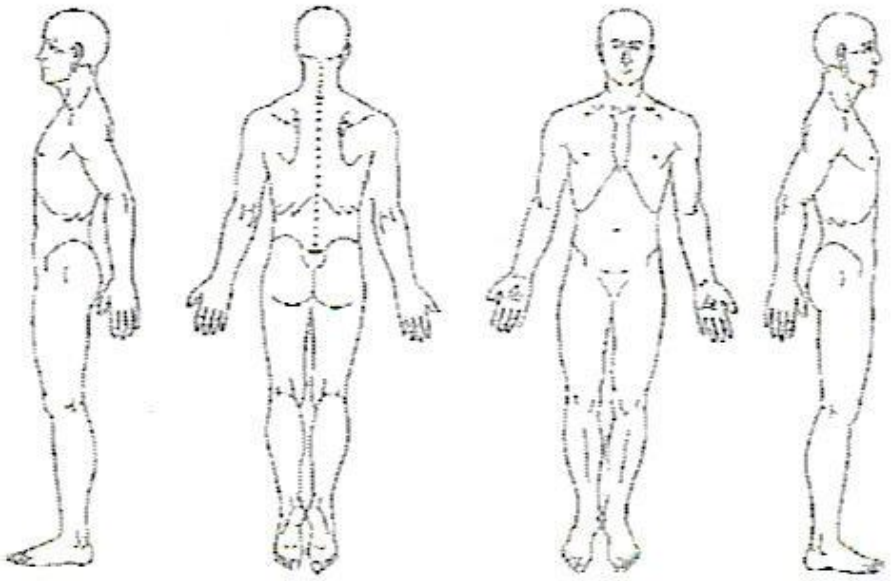
Description of Condition

Mark any area(s) of discomfort with the following key:

A =Ache N =Numbness B = Burning T = Tingling S = Stiffness O = Other



On a scale of one to ten how intense are your symptoms? Not intense ⓪①②③④⑤⑥⑦⑧⑨⑩ Unbearable

Additional comments you would like the doctor to know: _____

_____

_____

_____

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For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
○	○	Abdominal Pain	○	○	Elbow/upper arm pain	○	○	Liver/Gall Bladder Disorder
○	○	Abnormal Weight gain/loss	○	○	Epilepsy	○	○	Loss of Bladder Control
○	○	Allergies Headache	○	○	Excessive thirst	○	○	Low back pain
○	○	Angina	○	○	Frequent Urination	○	○	Mid back pain
○	○	Ankle/foot pain	○	○	General Fatigue	○	○	Neck pain
○	○	Arthritis	○	○	Hand pain	○	○	Painful Urination
○	○	Asthma	○	○	Heart attack	○	○	Prostate Problems
○	○	Bladder Infection	○	○	Hepatitis	○	○	Shoulder pain
○	○	Birth Control Pills	○	○	High blood pressure	○	○	Smoking/tobacco Use
○	○	Cancer	○	○	Hip/upper leg pain	○	○	Stroke
○	○	Chest Pains	○	○	HIV/AIDS	○	○	Systematic Lupus
○	○	Chronic Sinusitis	○	○	Hormone Therapy	○	○	Thoracic Outlet Syndrome
○	○	Depression	○	○	Jaw pain	○	○	Tumor
○	○	Dermatitis/Eczema	○	○	Joint swelling/stiffness	○	○	Ulcer
○	○	Dizziness	○	○	Kidney Stones	○	○	Upper back pain
○	○	Drug/Alcohol Use	○	○	Knee/lower leg pain	○	○	Wrist pain

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Consent for Treatment

Assignment & Release - By signing below, I authorize Sunset Hills Chiropractic to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Sunset Hills Chiropractic and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.

By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient

HIPAA & Authorization to Release

I understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operation, and coordination of care. I understand that should I need a more detailed account of my policy and procedures concerning the privacy of my Patient Health Information, I am welcome to read the HIPAA Notice that is available at the front desk before signing this consent.

In Order for our office to provide ANY information to your Spouse, parent, relative or other designates, we must have your permission. (This would include appointment schedules, X-Rays, receipts, Insurance Information, health records and any other information that pertains to your treatment.) You may indicate your permission by listing names here:

My information may be shared with: (List Names and relationship to patient)

Patient's Signature: _____ Date: ___/___/___

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Accident Information

Name:_____Date of Birth:_____

1. Date of Accident: _____Time: a.m./p.m.

2. Driver of car: _____Where you were seated:_____

3. Owner of car: _____Year and Model of car:_____

4. Visibility at time of accident: poor/fair/good/other: _____

5. Road conditions at time of accident: icy/rainy/wet/clear/dark/other: _____

6. Where was your car struck? right/left/rear/front/side/other: _____

7. Type of accident: □ head-on collision □ broad-side collision □ rear-end collision

□ front impact □ rear-ended □ car in front □ non-collision: _____

8. What part of the car was damaged? _____

9. Describe what happened to you upon impact? _____

10. Did you see the accident was about to happen? □ Yes □ No

11. Did you brace for impact? □Yes □ No

12. Were you wearing a seatbelt? □ Yes □ No

13. Were you wearing a shoulder harness? □ Yes □ No

14. Does the car have headrests? □ Yes □ No

15. If yes, what was the position of your headrest? □ top of headrest even with bottom of head

□ top of headrest even with top of head □ top of headrest even with middle of head

16. Was your car braking? □ Yes □ No Was the other car braking? □ Yes □ No

17. Was your car moving at the time of the accident? □ Yes □ No

If yes, how fast would you estimate you were going? _____

18. How fast would you estimate the other car was traveling? _____

19. What was the position of your head and body at the time of impact?

□ head turned left/right □ body straight in sitting position □ head looking back

□ body rotated left/right □ head straight forward □ other:_____

20. At the time of the accident, recall what parts of your head or body hit what parts of the vehicle:

_____

_____

21. As a result of the accident were you: □ rendered unconscious □ dazed □ other: _____

22. Could you move all parts of your body? □ yes □ no

If no, why? _____

23. Were you able to get out of the car and walk unaided? □ yes □ no

If no, why not? _____

24. Did you have any cuts or bruises from this accident? □ yes □ no

If so, where? _____

25. Describe how you felt immediately after the accident? _____

_____

How did you feel later that □ day □ night? _____

How did you feel the next day(s)? _____

26. Check symptoms apparent <u>since</u> the accident:

□ headache	□ loss of smell	□ numbness in fingers	□ neck pain/stiffness
□ loss of taste	□ cold hands	□ mid-back pain	□ loss of memory
□ cold feet	□ low-back pain	□ fatigue	□ diarrhea
□ tension	□ constipation	□ pain behind eyes	□ shortness of breath
□ chest pain	□ dizziness	□ irritability	□ nervousness
□ fainting	□ depression	□ cold sweats	□ anxious
□ sleeping problems	□ loss of balance	□ numbness in toes	

□ ringing/buzzing in ears □ eyes sensitive to light □ other:_____

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27. Have you missed time from work? □ yes □ no Work hours are: □ full-time □ part-time

If you have missed time from work, how much time have you missed? _____

28. Did the accident occur during your work hours? □ yes □ no

29. Did you seek medical help immediately/soon after the accident? □ yes □ no

If yes, how did you get there? _____

30. Doctor/hospital/clinic seen: _____ Date: _____

31. What was done? _____

Were x-rays taken? □ yes □ no If yes, of what body part? _____

32. What treatments/prescriptions were given? □ bed rest □ brace □ adjustments □ medications

33. What benefit(s) did you receive from treatment(s)? _____

_____

34. Date of last treatment: _____

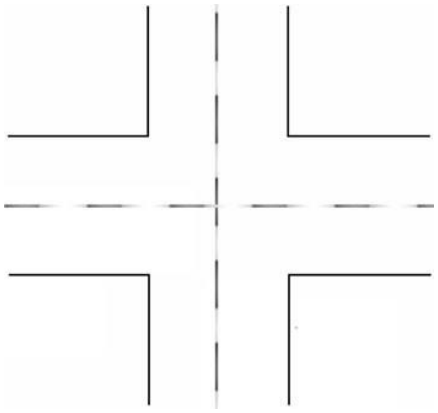
35. Are any of your activities of daily living any different now compared to before the accident?
□ yes □ no

List anything you are unable to do: _____

List anything that is painful to do: _____

List anything that is difficult to do: _____

36. Indicate on the diagram below how the accident happened:



Comments: _____

_____

_____

_____

37. Do you have an attorney handling this case? □ yes □ no

If yes, who? (name/address)_____

_____

Insurance Information
Patient's personal insurance: _____

Insured's name (if other than patient) _____

Policy #: _____

Insurance Company Name: _____

Phone#: _____

Address: _____City: _____State/Zip:_____

Claim #: _____Adjuster's name/phone:_____

Other party's insurance: _____

Insured's name (if other than patient) _____Policy #: _____

Insurance Company Name: _____Phone#: _____

Address: _____City: _____State/Zip: _____

Claim #:_____Adjuster's name/phone: _____

Other insurance: _____

Insured's name (if other than patient) Policy #: _____

Insurance Company Name: _____

Phone#: _____

Address: _____City: _____State/Zip: _____

Claim #: _____

Adjuster's name/phone: _____