Henrikson Chiropractic

Patient Information

General Information

Date:____________________

Patient Name:____ **Date of Birth:**________________

Patient Sex: M F **Age:**__________ **Email:**____

Address:____

City: _________________________________ **State:**_____________ **Zip:** _________________

Cell #:_________________________ **Home #:**_______________________ **Work#:**_______________________

Patient Employer:________________________________ **Patient Occupation:**_____________________________

How did you hear about us?____

Complaint History

Describe your current complaint and how the problem began:_________________________________

____

How long have you had this condition?___________________________________ **Date of onset:**___________

How would you describe the pain? (Circle all that apply)

Sharp Soreness Throbbing Tingling Dull Stiffness

Spasm Burning Ache Weakness Numbness Shooting

How would you rate the intensity of your pain? (Circle the appropriate number)

0 1 2 3 4 5 6 7 8 9 10

(no pain) (moderate pain) (terrible/unbearable pain)

How often is the pain present?

Constant(81-100%) Frequent(51-80%) Occasional(25-50%) Intermittent(25% or less)

Since the problem began, is the pain:

Getting worse Getting Better Staying the same

What makes your pain better?

Nothing Walking Sitting/Standing Exercise Lying Down Computer use

What makes your pain worse?

Nothing Walking Sitting/Standing Exercise Lying Down Computer use

Personal Injury Intake Form

About Your Accident:

Date & Time of Accident:___/___/___ , ________ **am / pm**

Where were you seated? (Please circle) **Driver / Front Passenger / Rear Passenger**

Were you looking straight ahead, to the left or right?______________________

Did the police come to the accident site? **Yes / No** Was a police report filed? **Yes / No**

Was a ticket issued? **Yes / No** If yes, to whom was it issued to?________________

Your seatbelt was: **On / Off** Did the airbags deploy? **Yes / No** Number of people in your vehicle: ______

The headrest was: (Please circle) **Above / Below / At the base of your head**

Did any part of your body strike anything in the car? **Yes / No**

If yes, please explain: ____

____

Did your vehicle impact another vehicle or structure? **Yes / No**

Please briefly describe your accident: ____

____

What is the make and model of the vehicle you were driving?____

What was your approximate speed?_____________________

What is the make and model of the other vehicle? ____

Name of the street/intersection the other vehicle was traveling on? ____

What was their speed? ________________

What direction did the impact to your vehicle come from? (Please circle)

Front / Rear / Right / Left / Other

After Your Accident:

Did you lose consciousness during the accident? **Yes / No** If yes, for how long?___________________________

Please describe how you immediately felt after the accident? ____

____

Have you gone to a hospital or seen any other doctors? **Yes / No** If so, who? ________________________________

When did you go?(Please Circle) **Just after the accident / next day / 2 or more days later**

How did you get there? (Please Circle) **Ambulance / Private Transportation**

What kind of treatment did you receive? ____

Were there X-Rays, MRI, CT Scans, etc. taken? **Yes / No**

Was medication prescribed? **Yes / No**

Damage to Vehicle:

Did your vehicle hit anything after the accident? **Yes / No** If yes, please describe:

____

____

What was the estimated damage to the vehicle you were in? ____

Who is your auto insurance company? ____

Do you have Medical Payments (MEDPAY)? **Yes / No** If yes, how much? ________________________________

If known, what is your claim number and name of your adjuster? ____

Are you currently represented by an attorney? **Yes / No** If yes, who? _______________________________________

If not, would you like us to refer you to one of our expert attorneys? ________________

Past or present symptoms, conditions or habits:

Tobacco Use: Past Present Occasional Moderate Heavy

Alcohol Use: Past Present Occasional Moderate Heavy

Caffeine Use: Past Present Occasional Moderate Heavy

Pregnancy: Past Present

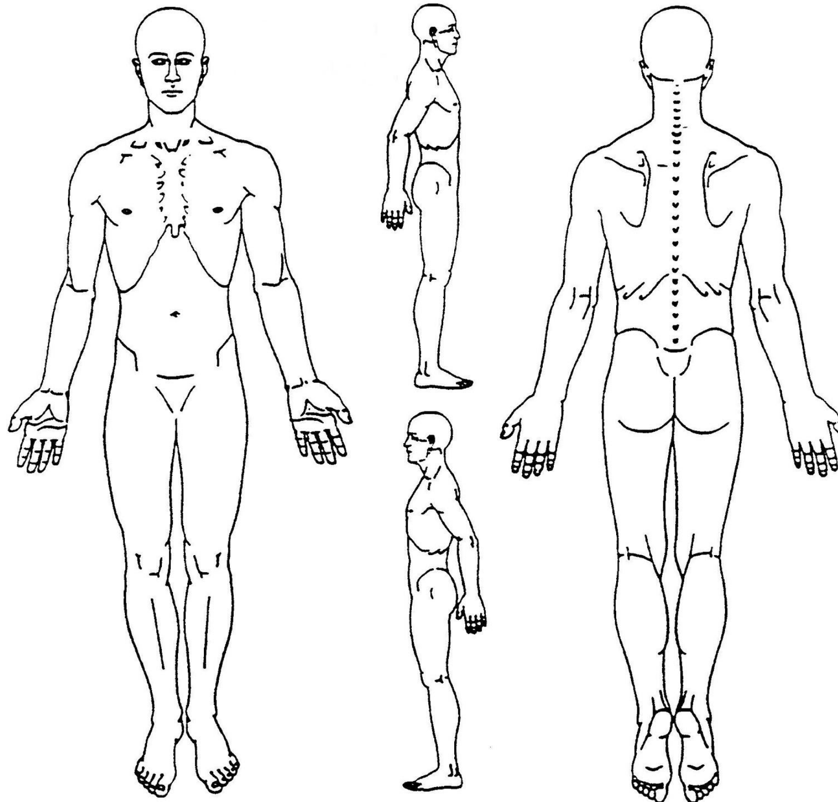
Surgical Procedure: Past Present

Please list:____

Allergies:____

Emergency Contact: ______________________________ **Phone #:**__________________________

Please mark your areas of pain with “X’s”



Henrikson Chiropractic LLC.

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Email:Henriksonchiropractic@gmail.com

Letter of Protection

Patient Name: ____ Accident Date: ____/____/ ____

Attorney Name: ____

Doctor Name: ____

We, the undersigned patient and attorney, will protect the interests of Henrikson Chiropractic, LLC. (practice) out of proceeds from any settlement, judgement or verdict, relating to the accident listed above.

By "interests," we mean any outstanding balance owed to the practice for treatment rendered to me, the patient, for injuries sustained on the above date.

This letter of protection shall not be modified or revoked without the written consent of Henrikson Chiropractic LLC.

Patient's Signature

Date: ___/___/___

Attorney's Signature

Date: ___/___/___

Doctor's Signature

Date:___/___/___

Authorization and Releases

Name:____

Consent for Treatment

I, the undersigned, hereby authorize the doctor(s) and whomever they may designate as their assistant to perform diagnostic tests, and to administer treatment as is necessary. I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are in arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that my amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account.

HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

____

Patient Signature **Date**

Authorization to Release Medical Information

I authorize the doctor(s) to release any medical information pertinent to my treatment plan to my insurance company or an authorized representative for review. This authorization for release of information shall remain valid for the term of my coverage under my current policy. I certify that all insurance information given to this clinic, Taylor Chiropractic & Wellness is correct and complete. I also know that I am entitled to receive a copy of this authorization form.

____

Patient Signature **Date**

Consent for Treatment of Minor (if applicable)

I hereby authorize the doctor(s) and whomever they may designate as their assistant(s) to perform diagnostic tests, and to administer treatment as they deem necessary for my _____________(Indicate relationship to child. ie: daughter, son, etc.) (Child's name)______________________________

____

Parent/Guardian Signature **Date**